State of Vermont
Agency of Human Services

Global Commitment to Health
11-W-00194/1

Annual Report
for FFY 13
October 1, 2012 to September 30, 2013

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I. Background and Introduction

The Global Commitment to Health is a Demonstration Initiative operated under a Section 1115(a) waiver granted by the Centers for Medicare and Medicaid Services (CMS), within the Department of Health and Human Services (HHS).

The state of Vermont is a national leader in making affordable health care coverage available to low-income children and adults. Vermont was among the first states to expand coverage for children and pregnant women, through the 1989 implementation of the state-funded Dr. Dynasaur program. In 1992, Dr. Dynasaur became part of the state-federal Medicaid program.

When the federal government introduced the state Children's Health Insurance Program (CHIP) in 1997, Vermont extended coverage to uninsured and under-insured children living in households with incomes below 300 percent of the Federal Poverty Level (FPL).

In 1995, Vermont implemented an 1115(a) waiver program, the Vermont Health Access Plan (VHAP); the primary goal was to expand access to comprehensive health care coverage for uninsured adults with household incomes below 150 percent (later raised to 185 percent) of FPL, through enrollment in managed care. VHAP also included a prescription drug benefit for low-income Medicare beneficiaries who did not otherwise qualify for Medicaid. Both waiver populations pay a modest premium on a sliding scale based on household income.

Implemented October 1, 2005, the Global Commitment converted the (then Office) Department of Vermont Health Access (DVHA), the state's Medicaid organization, to a public managed care model. The Agency of Human Services (AHS) pays DVHA a lump sum premium payment for the provision of all Medicaid services in the state (with the exception of the Long-Term Care Waiver, managed separately).

A Global Commitment to Health Waiver amendment, approved October 31, 2007 by CMS, allowed Vermont to implement the Catamount Health Premium Subsidy Program with the corresponding commercial Catamount Health Plan (implemented by state statute October 1, 2007) for incomes up to 200 percent of the FPL to reduce the number of uninsured citizens in Vermont.

The Catamount Plan is a health insurance product offered in cooperation with Blue Cross Blue Shield of Vermont and MVP Health Care that provides comprehensive, quality health coverage at a reasonable cost regardless of how much an individual earns. Subsidies are available to those who fall at or below 300 percent of the FPL. On December 23, 2009 a second amendment was approved that allowed Federal participation for subsidies up to 300 percent of the FPL, and allowed for the inclusion of Vermont's supplemental pharmaceutical assistance programs in the Global Commitment to Health Waiver. Renewed January 1, 2011 the current waiver continues all of these goals.

The Global Commitment provides the state with the ability to be more flexible in the way it uses its Medicaid resources. Examples of this flexibility include new payment mechanisms (e.g., case rates, capitation, combined funding streams) rather than fee-for-service, to pay for services not traditionally reimbursable through Medicaid (e.g., pediatric psychiatric consultation) and investments in programmatic innovations (e.g., the Vermont Blueprint for Health). The managed care model also requires inter-departmental collaboration and reinforces consistency across programs.

One of the Terms and Conditions of the Global Commitment Waiver requires the State to submit an annual report. This is the report for the seventh waiver year, federal fiscal year 2013, which ended on September 30, 2013.

II. Highlights and Accomplishments

- The AHS and the DVHA worked diligently with CMS on Global Commitment waiver renewal during FFY13, which was approved for October 2, 2013 through December 31, 2016.

- Throughout FFY13, the State of Vermont put forth significant effort in developing Vermont Health Connect, a state-based health benefit exchange for individuals and small businesses in Vermont, which was launched on October 1, 2013. To date, nearly 88,000 Vermonters have submitted applications for coverage through Vermont Health Connect.

- Efforts were initiated for development of the enterprise MMIS RFP during 2013.

- The AHS collaborated with community providers to create a coordinated, systemic response to the complex issues of opioid addictions in Vermont, referred to as the Care Alliance for Opioid Addiction (a Hub and Spoke model).

- External Quality Review - the DVHA with its IGA partners was found to be 99% in compliance with the external quality review standards.

- In 2013, the Managed Care Medical Committee (MCMC) was re-organized with new chairpersons, some new members, and a new charter and renewed vision for the work of this committee. The MCMC members bring a diverse range of expertise in clinical care, clinical policy-making and quality assurance work. The new charter charges this group with developing clinical criteria, documentation standards, utilization management policies and other policies/projects that have clinical implications. The Committee received training on data and analytics during 2013.

- The Compliance Committee was formed in 2013. The group will be responsible for guiding compliance activities and will work closely with our Quality Committee, Quality Unit, Program Integrity Unit and representatives from our IGA departments.

- The DMH made significant resource investments into community-based mental health services during FFY13, including expansion and improvement of emergency room, crisis and residential supports, flexible outpatient services, housing subsidies, and peer supports. Notably, two new residential providers began operation in FFY13: Middlesex Therapeutic Community Residence, and Second Spring – Westford.

III. Project Status

i. Vermont Health Connect

The State of Vermont launched Vermont Health Connect, a state-based health benefit exchange for individuals and small businesses in Vermont, on October 1, 2013. To date, nearly 88,000 Vermonters have submitted applications for coverage through Vermont Health Connect. Unexpected technological challenges in the project have led the State to expand options available to Vermonters through the open enrollment period. This includes allowing small businesses to enroll directly through insurance carriers and individuals to extend their current coverage until the end of March 2014. The State is focused on ensuring that as many individuals as possible are enrolled in coverage, while the SOV team continues to make progress on future development.

The State leveraged federal resources to procure, design and implement the additional technological infrastructure needed to operate a federally compliant health insurance marketplace. This innovation coincides with Vermont's overarching goal of modernizing the State's integrated eligibility system for all of its health coverage programs. The State continues to advance these efforts to ensure the ultimate development of one system to determine eligibility for Medicaid, CHIP, and Vermont Health Connect. The State seeks to reuse functionality and share data and logic across human services to improve efficiency and scalability.

On December 17th, 2012 Vermont signed a system integration contract with CGI to purchase services for the implementation of core technology components necessary to create Vermont Health Connect. CGI has partnered with Exeter Consulting Group to implement the OneGate Exchange Product for the State. This pre-configured product greatly expedited Vermont's delivery and positioned Vermont Health Connect to meet its mission to provide Vermonters' access to public and private healthcare benefits throughout open enrollment. OneGate leverages existing State software licenses (Oracle) and provided out-of-the-box ACA compliance rules for eligibility and the enrollment application. Additionally, OneGate had pre-designed the workflows for SHOP, Plan Selection, and the back-end case management process.

a. Legislative Activity

Vermont benefits from a high level of support for healthcare reform at the highest levels of State government. Act 48 of 2011 authorized Vermont Health Connect, Vermont's Health Insurance Marketplace, within the existing DVHA, the State's Medicaid agency. Vermont Health Connect employs a governance structure that includes an Executive Committee and a Deputy Commissioner, who serves as the Chief Executive Officer for the Exchange. The State also convened a 30-member Medicaid and Exchange Advisory Board, comprised of key Vermont stakeholders, to provide feedback on decisions.

In 2012 and 2013, three additional pieces of legislation were passed, facilitating further development of Vermont Health Connect. In May 2012, Act 171 was signed by Governor Peter Shumlin (i.e., H. 559, "An Act Relating to Health Care Reform Implementation"). Act 171 included the following core policy components:

- Merging the individual and small group markets;
- Eliminating an "outside-Exchange" market by permitting health issuers to sell insurance for individuals and small employers only through Vermont Health Connect;
- Retaining the current Vermont definition of a small employer as an employer with 50 or fewer employees until January 1, 2016;

- Mandating Vermont Health Connect to offer Bronze plans (initially removed through Act 48);
- Separating broker commissions from health plan premiums, and requiring that the commissions be charged directly as a separate, transparent fee; and
- Allowing the State to compensate brokers for assisting with qualified health plan enrollment and application for premium tax credits and cost-sharing reductions through Vermont Health Connect.

In May 2013, the Vermont Legislature approved two health reform initiatives. H.107 focuses on technical changes and specific policy directives related to Vermont Health Connect operations, such as the exclusion of seasonal workers from the calculation of exchange eligibility for small businesses. The Administration also requested emergency rulemaking authority from the legislature regarding changes to eligibility, enrollment, renewals, grievances and appeals, public availability of program information, and coordination across health benefit programs. This authority allows the State to revise and coordinate existing agency health benefit program rules into a single integrated and updated code for the effective launch and operation of Vermont Health Connect.

The State Budget Bill allocated additional premium assistance and cost-sharing reductions for low-income Vermonters. This affordability provision has reduced premium costs by an additional 1.5% of household income for Vermonters up to 300% FPL who are purchasing non-group policies through Vermont Health Connect. In addition to state-based premium assistance, the law also increases cost-sharing assistance for Vermonters between 200% FPL and 300% FPL.

b. Outreach & Education

Vermont continues to prioritize engagement and collaboration with key partners and stakeholders to ensure the successful design, development, and implementation of Vermont Health Connect. The State uses advisory meetings, public forums, media inquiries, and other interactions to educate Vermonters about the State's vision for health care reform and the role of the Exchange in that vision. The State also values the input of Vermonters in the process of building the Exchange, soliciting input through formal structures and information interactions.

An important priority for Vermont Health Connect is providing effective consumer assistance to individuals and small businesses. Vermont has developed goals for the consumer experience within the Health Insurance Marketplace for both individuals and small businesses. The mission of Vermont Health Connect is to provide all Vermonters with the knowledge and tools needed to easily compare and choose a quality, affordable, and comprehensive health plan. Vermont Health Connect has identified four functions that it feels are critical in providing the level of consumer support required by the ACA.

1. Creating a call center with a toll-free hotline to assist all Vermonters seeking health insurance;
2. Developing a broad network of Navigators and in-person assister personnel;
3. Working closely with agents and brokers; and
4. Building on the capacity of the existing Office of the Health Care Ombudsman

The State utilized federal funding to contract with GMMB for the creation of a comprehensive outreach and education plan for Vermont Health Connect. The Outreach and Education Plan

provides direction on Vermont Health Connect's target audiences, outreach strategies, materials development, media, and state employee communications. The target audiences detailed in the plan address the populations identified in 45 CFR 155.130. The plan also adds key sub-populations to the primary audiences list, including (1) young adults (18-34), as they make up the largest portion of the uninsured population in Vermont, and (2) Catamount Health beneficiaries, as they were covered by a State program and are transitioning to Vermont Health Connect in 2014. Additionally, because Vermont has one of the lowest uninsured rates in the country but a high underinsured rate, Vermont's underinsured population is a priority for Vermont Health Connect.

The Outreach and Education Plan explores a variety of tactics for reaching these populations with the goal of engaging them and driving them to the Vermont Health Connect website or an in-person assister where they can learn more about Vermont Health Connect and get enrollment assistance. The plan was completed in late 2012 and has been implemented in stages, beginning in early 2013. As a part of its outreach and education activities, Vermont Health Connect has deployed a statewide In-Person Assister Program (IPA) consisting of trained and registered Navigators, Brokers, and Certified Application Counselors. Using Level 1A funding, Vermont contracted with HES Advisors and their subcontractors at Cope & Associates, Inc. to develop an IPA training program that met federal guidelines and ensured that individuals would be appropriately trained. A comprehensive training plan was developed and executed. The plan included specific training goals, a competency model, curricula development, and high level module content. To date, the State has trained and registered 199 Navigators, representing 31 organizations and 76 locations across the state, as well as 65 Certified Application Counselors and 154 registered brokers, who are currently working in the field to sign individuals and businesses up for coverage through Vermont Health Connect.

c. Plan Management

In August 2012, the DVHA provided recommendations on essential health benefits, pediatric vision and dental coverage, and plan design to the Green Mountain Care Board (GMCB). GMCB approved a popular BCBSVT package as the State's benchmark plan. GMCB also accepted the DVHA's recommendation on pediatric vision and dental coverage, making CHIP the benchmark plan for pediatric oral and FEDVIP the benchmark plan for pediatric vision. Finally, GMCB accepted the DVHA's proposed approach to the development of exchange plan designs through which each participating carrier would offer state-specific "standard" plan designs as well as the potential for additional "choice" plans through Vermont Health Connect. State-specific plans are offered at all metal tier levels – two bronze, two silver, one gold, and one platinum. Carriers were also provided with the option of crafting and offering non-standard plans within set parameters at the bronze, silver, and gold metal tier levels. Both carriers accepted this option and submitted non-standard plan designs that offer a range of choices among the metal levels, prioritize low cost-sharing for primary care services and generic drugs, and allow portability. The inclusion of portability ensures that individuals have consistent coverage options regardless of their employment situation. The State issued an RFP for these plans in November 2012. Forms were submitted by carriers in January 2013 and rates were filed in March 2013.

Form and Rate Review is conducted by the Department of Financial Regulation (DFR). Utilizing the actuarial expertise of Oliver Wyman, DFR completed its regulatory process in May of 2013, certifying 26 plans. These recommendations were provided to the GMCB and public hearings were held in June and July. In mid-July all 18 plans were approved by the GMCB after minor revisions. The DVHA Commissioner Mark Larson reviewed the plan submissions and chose 18 plans to be sold on Vermont Health Connect in 2014. In August, the State entered into contract

negotiations with Blue Cross Blue Shield, MVP, and Delta Dental to offer certified plans on Vermont Health Connect through the 2015 plan year.

In 2013, the State worked with DFR and the National Association of Insurance Commissioners (NAIC) to support upgrades to the System for Electronic Rate and Form Filing (SERFF) interface. The agreement allowed the State to use the web services developed by the NAIC to transfer SERFF data between the DFR and DVHA. This service provided the carrier plan data that was loaded in Vermont Health Connect to support plan selection and downstream enrollment processing for Vermonters who select Qualified Health Plans through Vermont Health Connect.

ii. Catamount Health and Employer-Sponsored Insurance

In 2013, enrollment in the Employer-Sponsored Insurance (ESI) program for the 138-185 FPL was approximately 420 people. Enrollment in the VHAP ESIA population greatly fluctuated this year but, on average, had approximately 250 recipients according to recent reports. Enrollment reporting for FFY 2013 is complicated by changes related to health care reform in Vermont and its impact on certain populations, namely the beneficiaries that have qualified for MAGI Medicaid. This population unenrolled in ESI plans or their employers stopped offering insurance, and the employees have since enrolled in coverage through Vermont Health Connect and are receiving subsidies. For similar reasons, enrollment in the Catamount Health premium assistance program decreased in 2013.

IV. Findings

i. *External Quality Review*

As a Managed Care model, the DVHA adheres to federal rules contained in 42 CFR 438. The AHS contracts with Health Services Advisory Group (HSAG) to conduct an external independent review of the quality outcomes and timeliness of, and access to care furnished by the DVHA to its Medicaid enrollees.

During this year, the AHS Quality Improvement Manager (QIM) worked with the External Quality Review Organization (EQRO) to prepare documents for the 2013 review activities. Before any activities could take place, a time line was reviewed and agreed upon. With this time line in place, a work plan was created for each of the three required activities. These documents included the following information: key task, due date, responsible party, and any applicable comments. Once completed, these documents were shared with DVHA and its IGA partners and made final ahead of the on-site and desk reviews. During this time, the PIP summary form, compliance review tool, and performance measure review guides were also developed by the EQRO with input from AHS QIM. These are the tools that are used by the EQRO to gather data that assesses DVHA's performance relative to quality assessment and improvement requirements as well as their ability to comply with State and Federal Medicaid managed care standards. In order to define the scope of the review, the AHS QIM finalized the performance measures subject to validation, identified the performance improvement expectations, and agreed upon the Medicaid managed care standards to be reviewed. This year's compliance review involved Federal and State access standards (including enrollment and disenrollment requirements); the PIP continued last year's project and addressed the appropriate use of medications for the treatment of congestive heart failure (CHF); and the performance measures subject to validation were the same as those validated in 2012. This allows for a continued opportunity to track and trend measure rates/results over time.

In addition to preparing physical documents, the AHS QIM worked with DVHA staff to help them prepare for the upcoming EQRO review activities. This included participating in face-to-face meetings and conference calls between DVHA and the EQRO to determine how best to report PIP activities undertaken during the past year on the newly approved PIP Summary Form, clarifying requirements on

the ISCAT document, as well as, clarifying the requirements associated with the measurement and improvement compliance standards. All tools and supporting documents were posted to the EQRO FTP site by the due date.

As in previous years, the AHS QIM attended both on-site EQRO reviews (i.e., review of compliance with standards and performance measure validation) and participated in the desk review of the performance improvement project. The EQRO conducted the validation of performance measures activities as outlined in the Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR), Version 2.0, September 1, 2012.* The performance measures were reported and validated for the measurement period of calendar year 2012 (i.e., January 1, 2012 through December 31, 2012). The EQRO conducted the review via the following off site activities: Information Systems Capabilities Assessment Tool (ISCAT) and supporting documents, source code (programming language) for performance measures, and SFY 2011–2012 Validation of Performance Measures report. On-site activities included the following: evaluation of system compliance, overview of data integration and control procedures, and opening/closing conferences. The EQRO determined that all performance measures were fully compliant with the specified standards and AHS should accept the measures as reliable and valid.

Specific EQRO validation of performance measures findings demonstrated that DVHA maintained a high degree of electronic claims data and automated processes which enhanced the validity of data. DVHA continued to invest time and resources in the performance measure reporting and audit reporting processes. In the performance measure and HEDIS team, DVHA strived to obtain complete and accurate data, and the quality team has been reviewing performance measure rates in detail to identify mechanisms to improve quality of care and outcomes for Medicaid beneficiaries, Performance trends continued to improve in some areas with other areas continuing to require additional DVHA improvement initiatives to increase the rates. DVHA continued to perform well for the *Antidepressant Medication Management*, *Annual Dental Visits*, and *Children's and Adolescents' Access to Primary Care Practitioners* measures. DVHA obtained a notable rate increase in the *Adult's Access to Preventive/Ambulatory Health Services—65+ Years* indicator and more modest increases for other cohorts. The indicators for *Comprehensive Diabetes Care* continued to be a challenge for DVHA. *CDC—Eye Exams* performed between the national Medicaid 25th and 50th percentile, while the other three indicators, (*HbA1c Testing, LDL-C Screening,* and *Medical Attention for Nephropathy)* fell below the national Medicaid 5th percentile. Although DVHA initially took the EQRO's recommendations to report this measure using hybrid reporting, due to insufficient planning time for medical record procurement and abstraction, DVHA decided to forgo hybrid reporting for HEDIS 2013. The *Use of Appropriate Medications for People with Asthma—5–11 Years* and several indicators for the *Well-child Visits in the First 15 Months of Life* measure (i.e., 2, 3, 4, and 5 Visits) also presented opportunities for improvement. For the *Use of Appropriate Medications for People with Asthma—5–11 Years* indicator, the HEDIS 2013 rate showed a decline from HEDIS 2012 for 4.48 percentage points, including a rank below the national Medicaid 25th percentile. Although there has been minor changes in the *Well-Child Visits in the First 15 months of Life* measure, most of the indicators for this measure ranked below the national Medicaid 25th percentile.

Also during this year, the EQRO reviewed DVHA's ability to comply with the Centers for Medicare & Medicaid Services (CMS) Access Standards (42 CFR 438 §206-210), the enrollment and disenrollment requirements from the CMS Structure and Operation Standards, at 42 CFR §438.226 as well as state-specific requirements contained in the AHS/DVHA intergovernmental agreement (IGA). The EQRO performed an office-based desk review of DVHA's documents as well as an on-site review that included reviewing additional documents, observing demonstrations of DVHA's information system capabilities related to areas such as coordination of care, and conducting interviews with key DVHA staff members. Of the 71 applicable requirements, DVHA obtained a score of *Met* for 69 of the requirements and a score

of *Partially Met* for 2 elements. As a result, DVHA obtained a total percentage of compliance score of 98.59 percent across the applicable elements, for a rounded score of 99.0 percent compliance. DVHA's performance represented a substantive improvement from its performance in the EQRO's 2009–2010 review of the same standards.

DVHA's overall percentage of compliance score was 99 percent, indicating strong performance and a thorough understanding of the Medicaid managed care standards and the associated AHS IGA requirements the EQRP reviewed. The EQRO identified the following DVHA strengths:

- As in the prior years when conducting compliance reviews, the EQRO continued to experience AHS' and DVHA's strong commitment to building systems of care and services that meet the applicable CMS and State requirements, but always with the goal of embracing beneficiary-focused decisions, processes, and services. DVHA staff members' enthusiasm for the work that they are doing and the palatable excitement they express about DVHA's new initiatives and continually doing the right thing for beneficiaries was very clear to the EQRO reviewers.
- At the time of the EQRO's review, AHS and DVHA were engaged in numerous State-level innovative change and improvement initiatives in service delivery and funding models. As noted earlier, AHS and DVHA are frequently recognized by CMS, national health care associations and organizations, other state Medicaid agencies, and the EQRO as pioneers, innovators, and among the most proactive and leading managed health care systems in the nation in providing services to beneficiaries.
- DVHA's documentation and the information staff provided during the interview demonstrated that the organization had (1) continued to increase the frequency and quality of it's monitoring of vendors'/contractors'/IGA partners' performance, and (2) enhanced inclusion of its IGA partners in planning and quality improvement discussions and initiatives.

For this year's 2012–2013 performance improvement project validation, DVHA submitted its continuing PIP topic: *Increasing Adherence to Evidence-Based Pharmacy Guidelines for Members Diagnosed with Congestive Heart Failure*. In its PIP evaluation and validation, the EQRO used the Centers for Medicare & Medicaid Services (CMS) publication, *Validating Performance Improvement Projects: A Protocol for Use in Conducting Medicaid External Quality Review Activities*, final protocol, Version 1.0, May 1, 2002 (CMS PIP Protocol). This year, the External Quality Review Organization (EQRO) evaluated the technical methods of the Performance Improvement Project (PIP) up to and including step ten (i.e., assess for sustained improvement). The EQRO's review determined that the PIP design (e.g., study question, indicator(s), population, sampling techniques, data collection methodology, and data analysis plan) and implementation was based on sound methodological principles and could reliably measure outcomes. The PIP received an overall *Met* validation status when originally submitted. DVHA elected not to resubmit the PIP for a second and final validation because the one evaluation element that received a *Not Met* validation score was related to indicator outcomes and could not be improved with a resubmission. Overall, 96 percent of all applicable evaluation elements received a score of *Met*. The percentage of applicable evaluation elements *Met* remained the same as the 2011–2012 validation score with the same evaluation element in Activity IX receiving a *Not Met* score. This was the third and final year DVHA conducted its PIP—*Increasing Adherence to Evidence-Based Pharmacy Guidelines in Members with Congestive Heart Failure*. DVHA's strong performance in the Design and Implementation stages indicated that the PIP was designed appropriately to measure outcomes and improvement. DVHA was able to achieve sustained improvement over comparable measurement periods without a statistically significant decline in performance.

After the desk and onsite reviews were conducted, the AHS QIM worked with the EQRO to develop final reports for each activity as well as the Annual Technical Report. This document combines the results of

all three external quality review activities and identifies strengths and challenges associated with the three activities as well as making recommendations to improve the timeliness, access, and quality of services provided by the MCE.

In 2013, the Managed Care Medical Committee (MCMC) was re-organized with new chairpersons, some new members, and a new charter and renewed vision for the work of this committee. The MCMC members bring a diverse range of expertise in clinical care, clinical policy-making and quality assurance work. The new charter charges this group with developing clinical criteria, documentation standards, utilization management policies and other policies/projects that have clinical implications. The Committee received training on data and analytics during the past year; additional trainings have been scheduled for 2014. Additionally, the MCMC selected, and is assisting, with a Performance Improvement Project (PIP).

The Compliance Committee was formed in 2013. The group will be responsible for guiding compliance activities and will work closely with our Quality Committee, Quality Unit, Program Integrity Unit and representatives from our IGA departments.

Finally, new drafts of our IGA documents were developed and edited during this year. The DVHA anticipates that the final drafts of these documents will be negotiated into signed agreements in early 2014. The new IGAs are designed to clarify major compliance, monitoring and reporting duties of both the DVHA and IGA partners.

ii. Quality Assurance and Performance Improvement Activities

During the first part of 2013, the DVHA Quality Director and the AHS Quality Manager collaborated to develop a new structure and focus for the quality committee and to identify the appropriate committee members. Meetings were held with the IGA partner representatives to review compliance activities, ongoing performance improvement efforts and opportunities for cross-departmental quality initiatives. As part of the ongoing oversight activities, the DVHA Quality Unit worked with the IGA partner representatives in gathering the evidence of compliance around authorization of services. Meetings were held with the Department of Mental Health (DMH) and the Vermont Department of Health (VDH) to update their authorization manuals. The new DVHA Quality Committee updated the committee charter, which included an increased focus on quality improvement. New members representing the IGA partners were identified and several meetings were held focusing on the development of the IGA partners' quality plans. The DVHA Quality Committee developed a new Quality Plan and Quality Work Plan, which encompassed quality planning, compliance and quality improvement. Work continued throughout the year on identifying quality indicators that each of the IGA partners will be reporting to the DVHA Quality Committee.

The DVHA Managed Care Compliance Director and the DVHA Quality Improvement Director worked to develop the DVHA Compliance Plan. The DVHA Managed Care Compliance Director is responsible for this plan and reports to the DVHA Quality Committee regularly on the oversight activities of the DVHA and the IGA partners. The committee identifies areas for improvement and tracks quality improvement projects.

The MCMC approved a new PIP focusing on improving follow-up care after psychiatric hospitalization. The project will be led by the DVHA Quality Unit and monitored by the Quality Committee. In December 2012 the DVHA was awarded the CMS Adult Quality Measures Grant. Utilizing resources from the grant, the DVHA began work on developing the infrastructure to produce 17 of the CMS adult core performance measures, including developing the capacity to perform the chart reviews necessary for measures that require the hybrid methodology. The DVHA has also implemented two PIPs utilizing

resources from the grant. The two projects are focused on increasing breast cancer screenings and improving initiation and engagement in substance abuse treatment. The DVHA will follow CMS protocols for implementing PIPs. Both projects include partners from across the AHS as well as community partners and stakeholders. The DVHA PIP titled "*Increasing Adherence to Evidence-based Pharmacy Guidelines for Members Diagnosed with Congestive Heart Failure"* was completed during this year and was validated by the external quality review organization.

In addition to the three formal PIPs, the DVHA continues to participate in the Agency Improvement Model (AIM) trainings and completed three informal process improvement projects. These three projects focused on improving the out-of-state referral process, decreasing the time for out-of-state provider enrollment exceptions, and increasing awareness of the psychiatric emergency bed programs.

During this year, the MCMC performed the final review of the Buprenorphine Practice guidelines and the guidelines were approved. A new provider mapping tool was presented to the committee which would improve the committee's ability to assess access to services. The new tool will provide the committee with data on travel times for PCPs and specialty care providers.

Members of the DVHA Quality Unit continued to participate in the AHS Performance Accountability Committee and developed a DVHA Performance Accountability Plan. Members also participated in the AHS Results Based Accountability steering committee.

Throughout the year the DVHA Quality Unit and the DVHA Data Unit worked closely on identifying and producing performance measures. Members of the DVHA Quality Unit participated in the committees to develop the measures for the ACOs under the SIM grant as well as the statewide Common Physician Measurement Group. Members of the DVHA Quality Unit also worked closely with the Blueprint for Health and UVM's Vermont Child Health Improvement Program (VCHIP) on the state awarded five-year CHIPRA Quality Demonstration Grant. Resources from the grant supported the Blueprint for Health's expansion to pediatrics and during this year work began on the evaluation of the grant activities.

a. Quality Strategy

Using the findings of the 2012/2013 EQRO Annual Technical Report as well as information designed to monitor plan performance (e.g., performance measures, beneficiary survey data, grievance/appeal reports, etc.), the AHS PAC will assess of the quality of managed care services offered by the Department of Vermont Health Access. During the process, the Vermont Quality Strategy will be reviewed to evaluate its effectiveness. While no issues with the current Quality Strategy were identified in the past year, it is expected that the PAC will recommend modifications to the strategy during the upcoming year. The modifications will allow the plan to conform to the new guidance provided by CMS as well align with the broader National Strategy for Quality Improvement in Health Care (National Quality Strategy). Modifications will also align the document with the Vermont AHS Strategic Plan. Finally, the AHS Performance Accountability Committee (PAC) will recommend that the updated version of the strategy follow the formatting requirements as set forth in Section 508 of the Rehabilitation Act (29 U.S.C. §794d). Once feedback has been incorporated, a draft of the strategy will be made available for public comment before adopting it in final. Going forward, the AHS Performance Accountability Committee will be responsible for conducting periodic reviews of the quality strategy.

iii. Evaluation Activities

During this year, the AHS Quality Improvement Manager worked with evaluation staff at the Pacific Health Policy Group (PHPG) to develop an evaluation report as well as an updated demonstration evaluation plan. A full evaluation report and modified evaluation plan accompanied Vermont's recent waiver renewal application. As the demonstration moves forward, the evaluation will continue to determine its progress toward accomplishing the three goals of increasing access, improving quality, and controlling costs and will include both quantitative and qualitative analyses of enrollment statistics, quality of health care measurement information, and beneficiary survey results. The AHS QIM will continue to work with evaluation staff at the Pacific Health Policy Group (PHPG) through the end of the current waiver period to finalize the evaluation. During this time, the AHS QIM will also continue to collaborate with other separate, yet related Vermont health reform evaluation activities in an attempt to align efforts, facilitate data needs, and minimize duplication of efforts as well as burden on project participants.

iv. Provider and Member Relations

In 2013, the Provider and Member Relations Unit coordinated communications to consumers regarding the State's health insurance exchange, health plans and other member information through various public communication channels. Articles about Vermont Health Connect were featured in the annual Green Mountain Care Member Newsletter (available via http://www.greenmountaincare.org/sites/gmc/files/1gmc-newsletter-fall-2013.pdf). These articles educated readers about the State's health insurance exchange and impending changes to insurance coverage. For example, an article titled "Is My Plan Changing?" addressed continuation of Medicaid and Dr. Dynasaur coverage for beneficiaries who met eligibility criteria, and coverage options relating to the sun-setting of CHAP, VHAP, ESIA and some pharmacy programs. Finally, consumers seeking information on health plans and member information for Green Mountain Care programs are linked to an updated website (http://www.greenmountaincare.org/) that provides easy navigation to relevant information about health plans and other member information, including links to Vermont Health Connect and how to apply for public plans.

V. Cost Containment Initiatives

i. Vermont Chronic Care Initiative

The goal of the Vermont Chronic Care Initiative (VCCI) is to improve health outcomes of Medicaid beneficiaries through addressing the increasing prevalence of chronic illness. Specifically, the VCCI is designed to identify and assist Medicaid beneficiaries with chronic health conditions in accessing clinically appropriate health care information and services; coordinate the efficient delivery of health care by attempting to remove barriers, bridge gaps, and avoid duplication of services; and educate, encourage and empower members to eventually self-manage their chronic conditions. The VCCI is a component of the DVHA health care reform goals and the supporting strategic plan. The VCCI employs 28 licensed and non-licensed professional staff, and contracts with an external vendor to provide supplemental services that include assistance with advanced data analytics and additional clinical and professional staff.

The VCCI uses a holistic approach to evaluate both medical and behavioral health conditions, as well as the socioeconomic issues, that often are barriers to sustained health improvement (e.g. housing, pharmacy co-pay). The VCCI emphasizes evidence-based, planned, integrated and collaborative care for beneficiaries who exhibit high-prevalence chronic disease states, high-expense utilization, high medication utilization, and/or high emergency room and inpatient utilization for ambulatory care sensitive

conditions (ACS). Eligible members account for the top 5% of utilization of these services; they are on a trajectory to become "super-utilizers". There are roughly 32 chronic conditions that are generating high utilization patterns. Most recent data for the VCCI eligible cohort indicates that the top 5% accounts for 39% of the Medicaid spend. This includes 20% of all ACS ED costs, about 60% of ACS inpatient costs, and 88% of hospital readmission costs. Our strategy of embedding staff in high volume hospital and primary care sites continues to support population engagement in these high utilization areas at the point of need and supports transitions between hospital and community care settings.

Ultimately, the VCCI aims to improve health outcomes by supporting better self-care and lowering health care expenditures through appropriate utilization of health care services. By targeting predicted high cost beneficiaries, resources can be allocated where there is the greatest cost savings opportunity. The VCCI focuses on helping beneficiaries understand the health risks of their conditions and engage in behavioral changes to improve their overall health by facilitating access to, and effective communication with, their primary care provider (PCP).

The VCCI continues to expand upon the 2010 strategy to embed state-employed licensed staff in partner locations. At the end of FFY 2013, the VCCI had staff in 18 locations including nine AHS district office sites, two high-volume hospitals and seven PCP sites. The VCCI is scheduled for expansion to a tertiary care facility and a large FQHC in the first quarter of 2014. The embedded approach fosters strong provider relationships and direct referral for high risk populations, 'real time' case findings at the point of service within the PCP site or hospital. The goal of this approach is to reduce readmissions rates in this cohort from 93% of all hospital readmissions to 88%, per vendor data. The embedded model also provides an opportunity for enhanced coordination and planned transitions in care with hospital partners and primary care sites, as well as with home health agencies who may be delivering skilled nursing care after discharge.

All VCCI staff statewide interface with hospital discharge planners and case managers as appropriate (hospital liaisons), to facilitate transitions in care. Data exchanges from partner hospitals via secure FTP site transfers provide the VCCI team with daily census data for both inpatient and ED admissions. Currently four hospitals including our tertiary care center provide these data sets electronically (FAHC, Copley, NWMC, CVMC) while several others provide secure excel reports downloaded locally or via fax transmittals (Rutland Regional Medical Center, Northeastern Medical Center). Our goal is to eventually secure real time census data from all 14 hospitals in Vermont via FTP sites.

A persisting challenge for the VCCI has been timely recruitment and retention of our skilled nursing team. The State salary range for nurses is not competitive with other hospitals and vendor efforts, including those supported by the State (i.e., Blueprint, APS Healthcare vendor). To address this challenge, efforts have been made to request reevaluation of the State salary structure for these high demand positions which support health care reform goals.

The VCCI is strategically aligned with another important State health care reform efforts, the Blueprint for Health, their NCQA certified advance practice medical homes and local Community Health Teams (CHTs) funded by a multi-payer demonstration. VCCI staff function as members of the local CHT, supporting both patients and providers. This collaboration supports transition between levels of care and reduces redundancies, as VCCI supports the highest risk population and the CHT our less acute Medicaid members. The Blueprint expanded its efforts in FFY 2013 to include ACA-funded Health Homes, with a focus on substance abuse treatment. The VCCI is a partner in the resulting 'hub and spoke' teams and offers support - without duplication - for this vulnerable population including home visits and/or co-visits to providers as appropriate to support treatment adherence for behavioral and as well as physical health needs.

In addition to the core case management services for the high acuity population addressed above, the VCCI continued its expansion of specialty service case management in 2013. Two services expanded during this past year include the Pediatric Palliative Care Program (PPCP) and a High Risk Pregnancy case management service. The PPCP expanded to statewide operation and served roughly 40 children who met program criteria. The High Risk Pregnancy case management service has an initial launch planned for Franklin County in the first quarter of FFY 2014.

a. Pediatric Palliative Care

The PPCP serves Medicaid covered children under the age of 21 who live in Vermont and who have a life limiting condition from which they are not expected to recover. This initiative was legislatively supported and is now covered by the Global Commitment to Health Care 1115 Waiver. Services are administered by home health agencies and in the past year roughly 40 children and families have received services which may include care coordination, family training, expressive therapy, anticipatory bereavement counseling and medical respite. Quality improvement efforts are underway including development of audit tools and a family satisfaction survey with input from the statewide PPCP advisory committee.

b. High Risk Pregnancy

The VCCI expansion to include High Risk Pregnancy Case Management services was delayed due to challenges in recruitment of skilled nurses with this specialty training. Ultimately we hired two advance practice nurses including a nurse midwife and a women's health specialist with OB/GYN experience. These expert clinicians have developed the early tools and operating systems to support the launch of the high risk pregnancy service in our Franklin County service area, starting in the first quarter of FFY 2014. Expanded partnerships with sister departments within the AHS, including Department of Children and Families (DCF) and VDH, have been significant and include opportunities to integrate with DCFs Children's Integrated Services model (CIS) as well as the Maternal Child Health (MCH) services offered by VDH, office of local health. Similarly, the high risk pregnancy care management team will integrate with and support the ACA Health Homes for substance abusing pregnant women who are at considerable risk. Internal stakeholder meetings are anticipated in first quarter 2014 to facilitate this interface and prevent service redundancy.

c. APS Contract

Since 2007, the DVHA has contracted with APS Healthcare to assist the VCCI with providing disease management assessment and intervention services to Vermont Medicaid beneficiaries with chronic health conditions. The VCCI has progressively migrated away from traditional telephonic disease management and in 2011 implemented a combination of individual and population based strategies with primary focus on those in the top 5% of service utilization.

The VCCI has found this approach more effective with its highest cost/highest risk beneficiaries as staff are able to communicate directly at the local level with provider, partners, patients and their families to support direct engagement and trusting relationships. Our 2011 contract was 100% risk based with a guaranteed 2:1 ROI. In State FY (SFY) 2012, the VCCI delivered a net $11.5 million ROI which included both APS and the DVHA staff efforts. Consistent with this, we were also able to effectively reduce ED, IP and readmission rates. The DVHA is working towards procurement of an enterprise-level Care Management system, and the RFP process is currently underway. As a result, the DVHA further extended our contract with APS Healthcare on July 1, 2013 for a one year period with a new expiration date of June 30, 2014 to assure uninterrupted

operation during the procurement and transitional phase to the new enterprise level care management vendor.

APS is providing enhanced information technology and sophisticated decision-support tools to assist the VCCI case management staff to outreach the most costly and complex beneficiaries based on risk and ability to positively impact results. APS also continues to provide supplemental population-based gap in care reports to the VCCI field-based staff, who also support the Blueprint NCQA providers and their Community Health Team staff.

d. University of Vermont

The DVHA has also contracted with the University of Vermont (UVM) for VCCI program evaluation, and for assistance with identifying and implementing quality improvement projects. A clinical PIP was developed, focusing on heart failure which is one of the high cost, high risk chronic conditions that VCCI targets. The PIP was designed and implemented according to the CMS PIP requirements related to quality outcomes. The PIP topic addressed the appropriate treatment of heart failure, a progressive chronic condition. Patients with heart failure are managed through both APS and the DVHA's VCCI staff. An important component of outpatient management of heart failure is appropriate use of evidence-based pharmaceutical treatments. The DVHA received a score of 96% for the two-year intervention study which ended in FFY 2013. However, the VCCI continues to focus on this important condition as one of the five diseases for which the VCCI implements population-based provider health registries on gaps in evidence-based care.

The following are highlights of the VCCI for FFY 2013:

- The VCCI demonstrated a net savings in SFY 2012 of $11.5 million, in partnership with APS staff. Data for SFY 2013 will not be available until February 2014 due to the six-month claims run out required for calculation.
- Based on 2012 data, VCCI demonstrated improvements in adherence to evidence-based care for high risk members in multiple HEDIS measures. Compared to 2011, there was a reduction of ED usage by 4%, a reduction of Ambulatory Care Sensitive (ACS) inpatient hospitalizations by 8%, and a decrease in 30-day readmission by 11% in 2012.
- Annualized data on engagement in the VCCI during 2013 (as provided by APS Healthcare) indicates that the VCCI maintained an average monthly caseload of 686 members, with 1,718 unique members in FFY 2013. Unique members are beneficiaries who have been assigned to VCCI staff and have completed a Social Needs, Behavioral Risk or Transitions of Care Assessment. This represents a slight decrease in total cases worked despite an increase in the DVHA staff; however, there was also an increase in case duration based on higher acuity members.
- The VCCI expanded its embedded staff model within hospital and primary care practice sites. The VCCI now operates out of 18 different locations statewide including nine partner hospital and primary care locations and nine AHS office sites.
- The PPCP moved to statewide service for eligible Medicaid members under the age of 21 and with a life-limiting diagnosis. The program works in partnership with home health agencies for service delivery and with ongoing input from our statewide advisory committee, which includes community partners, providers, consumer/family members, and state legislators.
- Nursing recruitment and retention challenges persist despite a rewrite of all nursing positions in 2012 and adjustments in pay grade. A Market Factor has been under review by the State's

Department of Human Resources for an extended period and supplemental discussions on recruitment and retention strategies are scheduled in early 2014.

- The VCCI finalized the Heart Failure PIP, achieving a 96% score. Heart failure remains a quality improvement initiative of the VCCI statewide team and with APS colleagues.
- The VCCI completed multiple 'patient health registries' in 2013, including heart failure, asthma, depression, coronary artery disease, and diabetes.
- During 2013, VCCI initiatives successfully increased hospital data sharing on daily ED and IP census to include six of 14 hospitals. These reports are used by APS to help identify and outreach high risk patients at the point of service need.
- The DVHA had five additional nursing and medical social worker staff certified as case managers (CCM) by the Case Management Society of America.
- The VCCI Director was a guest speaker at the Center for Health Care Strategies (CHCS) and National Governors Association (NGA) sponsored meeting to support states in developing high utilizer programs to better manage care. The DVHA/VCCI was subsequently recognized by CMS in the July 2013 bulleting as one of six model programs working with 'super-utilizers'.
- Early efforts were initiated for development of the enterprise MMIS care management system RFP, with VCCI leadership as the business lead within the DVHA.
- VCCI aligned with ACA Health Homes for substance using/abusing populations via the DVHA/Blueprint and ADAP 'hub and spoke' efforts at the community level; in 2014, VCCI will continue to grow these relationships.

ii. Substance Abuse Services

In 2012, the DVHA established a Substance Abuse Unit in order to consolidate its substance abuse services into a single, unified structure and point of contact for prescribers, pharmacists, and beneficiaries. This unit provides seamless and integrated care to beneficiaries receiving Medication Assisted Therapy (MAT) and/or those participating in the *Team Care* program or who have a *Pharmacy Home*. The Substance Abuse Unit coordinates with the Care Alliance for Opioid Addiction (Hub and Spoke model), the VCCI and the DVHA Pharmacy Unit to provide beneficiary oversight and outreach. All beneficiaries receiving MAT services with buprenorphine have a Pharmacy Home that dispenses all their prescriptions. In addition to overseeing these programs, the Substance Abuse Unit coordinates and facilitates prescriber reconsideration requests and appeals when prior authorizations for controlled substances are denied.

a. Team Care Program

Federal Medicaid Law (42 CFR 431.54(e)) guides Vermont's policies around locking in members who over utilize Medicaid services and it states "If a Medicaid agency finds that a recipient has utilized Medicaid services at a frequency or amount that is not medically necessary, as determined in accordance with utilization guidelines established by the State, the agency may restrict the recipient for a reasonable period of time to obtain Medicaid services from designated providers only.

In many circumstances beneficiaries who exceed certain thresholds for opiates and other controlled substances or who utilize multiple prescribers and pharmacies to obtain controlled substance prescriptions are identified by the Team Care program. The Team Care program personnel (through a collaborative process) will often designate one prescribing physician and one

pharmacy (Pharmacy Home) to improve coordination of care and decrease over-utilization and misuse of services by participants.

Cost savings associated with the Substance Abuse Unit are expected through improved coordination of care and through reductions in over-utilization, misuse of medications, duplicative pharmacy payments, non-emergency health care services, unnecessary emergency room use, and inpatient detoxification.

b. *Buprenorphine Program*

The DVHA, in collaboration with the VDH's Alcohol and Drug Abuse Programs (ADAP), maintains a Capitated Program for the Treatment of Opiate Dependency (CPTOD). The CPTOD provides an enhanced remuneration for physicians in a step-wise manner depending on the number of beneficiaries treated by a physician enrolled in the program. The Capitated Payment Methodology is depicted in (Table 1) below:

Table 1. Capitated Payment Methodology

Complexity Level	Complexity Assessment	Rated Capitation Payment			
III.	Induction	$366.42			
II.	Stabilization/ Transfer	$248.14	+	BONUS	= Final Capitated Rate (depends on the number of patients per level, per provider)
I.	Maintenance Only	$106.34			

The total for the four quarters (October 2012- June, 2013) is $185,752.78 (Table 2).

Table 2. Buprenorphine Program Payment Summary FFY 2013

Buprenorphine Program Payment Summary FFY 2013	
FIRST QUARTER	
Oct-12	$23,454.82
Nov-12	$24,081.24
Dec-12	$16,365
1st Quarter Total	**$63,901.36**
SECOND QUARTER	
Jan – 2013	$9,818.74
Feb – 2013	$8,341.92
March- 2013	$13,541.08
2nd Quarter Total	**$31,541.08**

Grand Total	**$95,442.44**
THIRD QUARTER	
April – 2013	$14,120.22
May – 2013	$15,739.28
June - 2013	$250,772.68
3rd Quarter Total	**$50, 632.18**
FOURTH QUARTER	
July – 2013	$18,775.70
August – 2013	$8,341.92
September - 2013	$12,560.56
4th Quarter Total	**$39,678.16**
Grand Total	**$185,752.78**

The development of the Vermont *Buprenorphine Practice Guidelines* continues to be a collaborative effort with the Vermont Department of Health, Division of Alcohol and Drug Abuse Programs (VDH/ADAP) and other community partners. The Buprenorphine Practice guidelines are reviewed and updated every two years. The DVHA has revised the guidelines and they were submitted and approved by the MCMC in November 2012.

iii. Hub and Spoke Initiative: Integrated Treatment for Opioid Dependence

The AHS is collaborating with community providers to create a coordinated, systemic response to the complex issues of opioid addictions in Vermont, referred to as the Care Alliance for Opioid Addiction (a Hub and Spoke model). This initiative is focused on beneficiaries receiving Medication Assisted Therapy (MAT) for opioid addiction. MAT is the use of medications, in combination with counseling and behavioral therapies, to provide a whole patient approach to the treatment of substance use disorders. Overall health care costs are approximately three times higher among MAT patients than within the general Medicaid population, not only from costs directly associated with MAT, but also due to high rates of co-occurring mental health and other health issues, and high use of emergency rooms, pharmacy benefits, and other health care services.

The *Hub and Spoke* initiative creates a framework for integrating treatment services for opioid addiction into Vermont's state-led *Blueprint for Health* (*Blueprint*) model, which includes patient-centered medical homes, multi-disciplinary Community Health Teams (CHTs), and payment reforms. Initially focused on primary care, Blueprint's goals include improving individual and overall population health and improving control over health care costs by promoting heath maintenance, prevention, and care management and coordination.

The two primary medications used to treat opioid dependence are methadone and buprenorphine, with most MAT patients receiving office-based opioid treatment (OBOT) with buprenorphine prescribed by specially licensed physicians in a medical office setting. These physicians generally are not well-integrated with behavioral and social support resources. In contrast, methadone is a highly regulated treatment provided only in specialty opioid treatment programs (OTPs) that provide comprehensive addictions treatment but are not well integrated into the larger health and mental health care systems. To

address this service fragmentation, Vermont is developing a state plan amendment to provide Health Home services to the MAT population under section 2703 of the Affordable Care Act. Health Home services include comprehensive care management, care coordination, health promotion, comprehensive transitional care, individual and family support, and referral to community and social support services. State-supported nurses and licensed clinicians will provide the Health Home services and ongoing support to both OTP and OBOT providers.

The comprehensive *Hub and Spoke* initiative builds on the strengths of the specialty OTPs, the physicians who prescribe buprenorphine in office-based (OBOT) settings, and the local *Blueprint* patient-centered medical home and Community Health Team (CHT) infrastructure. Each MAT patient will have an established physician-led medical home, a single MAT prescriber, a pharmacy home, access to existing *Blueprint* CHTs, and access to *Hub* or *Spoke* nurses and clinicians for Health Home services.

Five regional *Hubs* are planned that build upon the existing methadone OTPs and also provide buprenorphine treatment to a subset of clinically complex buprenorphine patients, as well as serve as the regional consultants and subject matter experts on opioid dependence and treatment. *Hubs* will replace episodic care based exclusively on addictions illness with comprehensive health care and continuity of services.

Spokes include a physician prescribing buprenorphine in an OBOT and the collaborating health and addictions professionals who monitor adherence to treatment, coordinate access to recovery supports and community services, and provide counseling, contingency management, care coordination and case management services. Support is provided to *Spoke* providers and their Medicaid MAT patients by nurses and licensed addictions/mental health clinicians, added to the existing *Blueprint* CHTs. Similar to all CHT staff, *Spoke* staff are provided free of cost to MAT patients. Staff are embedded directly in the prescribing practices to allow more direct access to mental health and addiction services, promote continuity of care, and support the provision of multidisciplinary team care.

The below tables (Tables 3 and 4) present the patient counts for Hubs, Medicaid beneficiaries, individual Spoke providers, practice sites and staff.

Table 3. Hub Caseload by Region

Regional Hub Programs	Total Served	# Receiving Buprenorphine
Chittenden/Franklin/Grand Isle/Addison Counties	592	147
Windham/Windsor Counties	411	51
Washington/Lamoille/Orange Counties	148	45
Total	**1,151**	**243**

Table 4. Buprenorphine Providers, *Spoke* Funding & Staff Recruitment, and Medicaid MAT Beneficiaries by Region

Region	Providers	Medicaid Beneficiaries	Staff FTE Funding	Staff FTE Hired
Bennington	6	131	3	2.6
St. Albans	7	236	5	2.8
Rutland	5	206	4.5	2
Chittenden	12	352	7.25	7.35
Brattleboro	6	237	5	3.8
Springfield	3	41	1	1

The following are highlights of the Hub and Spoke Initiative for FFY 2013:

- The DVHA/Blueprint staff responded to informal and formal questions from CMS on the Health Home State Plan Amendment submitted to CMS the previous quarter. In consultation with CMS, Vermont consolidated two SPA applications into one with a start date of July 1, 2013.
- The Community Health Center of Burlington is now fully participating in the initiative. At present, these are the only two practices statewide not fully participating in the initiative. The DVHA efforts continue to encourage engagement in Spoke staffing from the Green Mountain Family Medicine in Rutland and Treatment Associates in Montpelier.
- By end of 2013, Spoke staffing was at 30.45 full-time employees (FTEs).
- Slightly less than 600 Medicaid beneficiaries are receiving MAT services through the Hub serving Chittenden, Franklin, Grand Isle and Addison Counties. This Hub program secured a second location in South Burlington and accelerated the rate of intakes for new patients.
- The Chittenden area Hub continued work with regional Buprenorphine providers and began to prioritize access and consultation from regional Spoke providers for patients who needed more intensive services.
- Performance contracts for the Hub programs in Central Vermont, Southeastern Vermont and the Rutland area were executed by ADAP, with program start dates of July 1, 2013 and November2013 respectively for the next phases of implementation.
- Spoke staff recruitment and deployment for Lamoille, Washington, Orange, Windham, and Windham counties was largely completed by October 2013.
- Spoke staffing plans for Bennington, Rutland, Essex, Orleans, and Caledonia Counties began this year, with program start dates of January 1, 2014 for the second phase of implementation.

iv. Pharmacy Program

The DVHA Pharmacy Unit is responsible for managing all aspects of Vermont's publicly funded pharmacy benefits program. Responsibilities include but are not limited to: processing pharmacy claims, making drug coverage determinations, administering drug reconsiderations and appeals, overseeing federal, state, and supplemental drug rebate programs, resolving drug-related pharmacy and medical provider issues, overseeing the contract with the prescription benefit management (PBM) contractor, overseeing and managing the Drug Utilization Review (DUR) Board, managing of the Preferred Drug List (PDL), assuring compliance with state and federal pharmacy and pharmacy benefits regulations, managing an annual GC drug spend of over $135 million drug budget, and analyzing trends and seeking innovative cost and quality initiatives. During FFY 2013, the DVHA Pharmacy Unit continued to focus on ensuring that members receive high quality, clinically appropriate, evidence-based medications in the most efficient and cost-effective manner. In addition, the Unit focused on health information exchange and administrative simplification. The key performance indicators for SFY 2013 include the following:

- Total GC Drug Spend was $135,414,438.21
- Total number of GC paid prescriptions was 1,496,369
  - % Brand Dugs= 351,550
  - % Generic Drugs= 1,144,819
- Gross Medicaid pharmacy PMPM (per member per month spend) was $84.94, a decrease of 0.19% compared to SFY 2012
- Buprenorphine and buprenorphine/naloxone are drugs used to treat opiate addiction. In SFY 2013, there was an 11% increase in utilization and 5.9% increase is cost compared to SFY 2012. These drugs continue to be the DVHA's most utilized and highest cost expenditure for drugs.

a. Reducing Administrative Burden on Providers and Beneficiaries

The DVHA is committed to reducing the administrative burden for providers and beneficiaries, in part by streamlining and improving the exchange of health information through electronic prescribing (e-prescribing) and electronic prior authorizations.

Documented health benefits of e-prescribing include medication safety advantages, increased system efficiency and reduction in routine problem orders. E-prescribing also is a key aspect of Meaningful Use and is consistent with Vermont's Health Information Exchange (HIE) goals. Vermont's latest SureScripts report indicates that 93% of pharmacies in Vermont are accepting e-prescribing and refill requests (e-Rx), and prescriptions are routed electronically by 82% of Vermont prescribers. Vermont is ranked seventh by SureScripts Safe-Rx ranking system (Ref: http://www.surescripts.com/about-e-prescribing/progress-reports/state.aspx?state=vt), which is based on patient eligibility, medication history, and the percentage of prescriptions routed electronically.

Effective November 1, 2012, the DVHA expanded its e-prescribing capabilities to include the entire SureScripts network, which dramatically increased the rate of e-prescribing for Medicaid providers. The DVHA continues to focus on increasing the percentage of Medicaid prescriptions sent electronically and improving the way Medicaid eligibility, medication history, and preferred drug list information are displayed to providers.

The DVHA currently is procuring a new PBM contract to begin January 2015. The contractor will be required to meet industry expectations for interoperability and health information exchange, including electronic prior authorization requests through web portals and provider electronic health records.

b. Improvements in Coordination of Benefits Process

In late 2012, the DVHA and its PBM implemented a new program known as enhanced coordination of benefits (e-COB) to improve point-of-sale pharmacy claims processing, which reduces the need for manual post-payment coordination-of-benefits intervention. This initiative relies on health insurance enrollment information obtained from various sources to identify and deny claims – at the point of sale – that should be billed to primary insurers before being billed to the DVHA, the payer of last resort. When the DVHA denies the claim, a message is included that provides the correct insurance billing information to the pharmacy. As this program was being discussed, the DVHA recognized it had additional information available from primary insurers that could be included in the eligibility file provided to the PBM vendor and consequently available at the point of sale. The combination of providing additional third party liability (TPL) information from primary insurers with PBM implementation of the e-COB program has resulted in decreased payment by the DVHA for beneficiaries with other insurance.

c. Psychotherapeutic Drug Management in Children

The DVHA's Pharmacy Unit participates in the *Psychiatric Medication for Children and Adolescents Trend Monitoring Group*, which includes members from the DMH, the DCF, Catamaran (DVHA's PBM) and psychiatrists. The purpose of the work group is to assess and reduce the use of antipsychotics in children in Vermont. With support from the VCHIP at the University of Vermont, the group analyzed data obtained through a survey of all prescribers of antipsychotic medications for Medicaid children. The survey served a dual purpose of informing the work group of prescribing practices in Vermont, and as a medical necessity review for each pediatric beneficiary being prescribed an antipsychotic. The work group now is developing best practice recommendations for Vermont's prescribing medical providers who serve children and adolescents with mental health needs.

The DVHA continues to participate in the Center for Health Care Strategies Technical Assistance (TA) Grant, known as *Improving the Appropriate Use of Psychotropic Medication for Children in Foster Care.* A goal of the TA grant is to track the overall well-being outcomes of children in foster care. To assess these outcomes the work group will implement use of the Child and Adolescent Needs and Strengths (CANS) tool. Additionally, Vermont is participating in the Psychotropic Monitoring Quality Improvement Collaborative (PMQIC), which also includes Illinois, New Jersey, New York, Oregon and Rhode Island. The PMQIC has developed a measure that all states will use to gather baseline and trend data over the three-year course of the grant.

d. Retrospective Utilization Reviews

In addition to a continued focus on the appropriate use of mental health medications, the DVHA and the DUR Board also perform retrospective drug utilization reviews of a variety of drugs with the potential for abuse. These reviews look at patterns of prescribing and utilization, and lead to development of recommendations for point-of-sale edits and educational initiatives to encourage evidence-based utilization. Reviews during 2013 included muscle relaxants, methadone, benzodiazepines, and the concurrent use of buprenorphine products with opiates.

e. Growth in Specialty Pharmacy Utilization

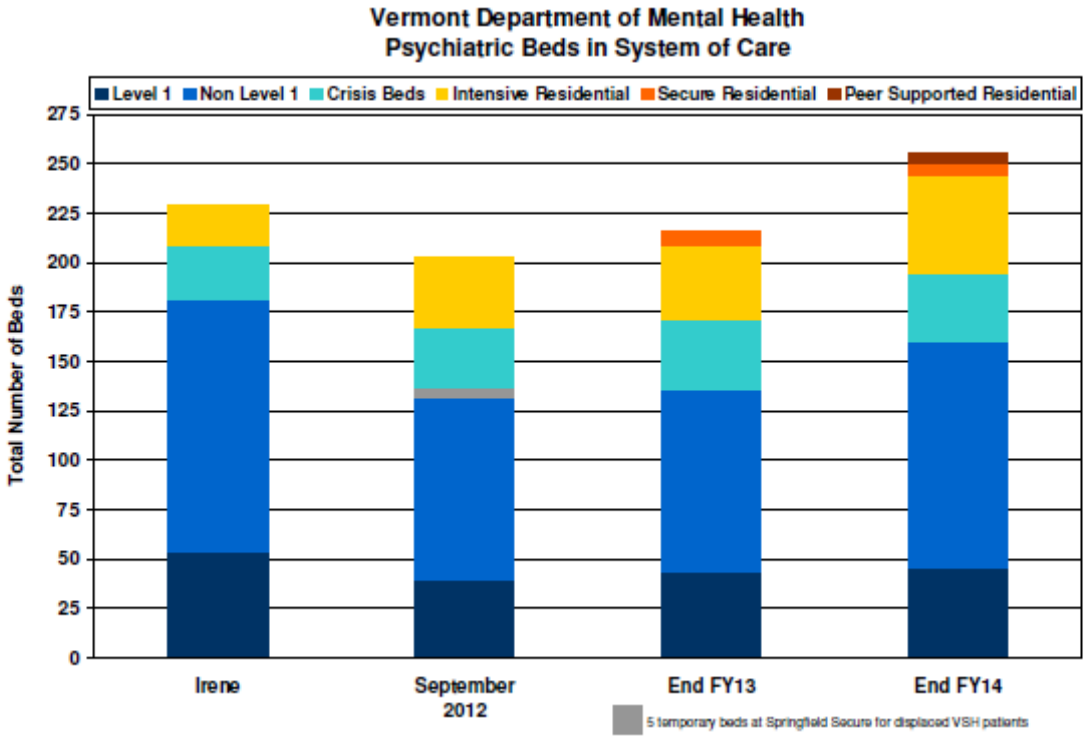
Specialty Pharmacy includes drugs that require difficult or unusual delivery processes or patient management before or after administration. Specialty drug utilization and spend have continued to increase. In Vermont, specialty drug costs were 16.2% of total paid pharmacy claims in SFY 2013, which represents an increase of 9.6% from the previous year. The top 20 specialty drugs represented 66% of specialty drug costs. Manufacturers' prices for widely used specialty drugs increased on average 8% from SFY 2010 to SFY 2011, and another 12% from 2011 to 2012.

Since November 2008, the DVHA has achieved cumulative savings of $3,586,676 by contracting with Wilcox Pharmacy of Vermont and BriovaRx of Portland, Maine, for specialty pharmacy services.

v. Mental Health System of Care

Following the abrupt closure of Vermont's only state-run psychiatric hospital due to flooding from Tropical Storm Irene just before the start of FFY 12, Vermont has continued to implement changes and enhancements to the adult mental health system of care in FFY 13 to reduce its reliance on institutional care and further build its community based system of care for persons with mental health conditions. The Department of Mental Health (DMH), consistent with the plan advanced by Governor Peter Shumlin and available Medicaid and Medicare funding resources, has continued to take significant steps forward in promoting a more person-centered, flexible and community based system with all the elements for a comprehensive and integrated system of care. Proposed major mental health reform legislation specific to this system reform was formally passed as Act 79 during the Vermont 2012 legislative session and continues to be the blueprint for system development and enhancement.

The enhancement of inpatient psychiatric, intensive residential and other hospital diversion beds in the system of care Pre-Irene and projected through the end of FFY 14 is represented in the following table and described in the text below.



Inpatient Care

Access to acute, psychiatric inpatient care remains a critical part of the overall mental health system reform efforts. Act 79 authorized up to 25 acute hospital beds to be developed at a new state-run hospital to be built in Berlin, Vermont, and the new facility (Vermont Psychiatric Care Hospital) is on target to open in the summer of 2014. During the fiscal year, DMH also established 28 "Level I" inpatient beds for individuals who would otherwise have been treated at the former 54-bed state-run hospital. These beds were created at the Brattleboro Retreat (14 beds), Rutland Regional Medical Center (6 beds), and Morrisville (8 temporary state-run beds). Long term agreements with Brattleboro Retreat and Rutland Regional Medical Center (RRMC) include provisions for a "no-refusal" system, reimbursement based on acuity and enhanced programming/staffing, and access to peer supports. One favorable element is that in these settings, care can be covered in part by Medicare, and even more so by Medicaid.

Durring FFY 13, the temporary eight-bed hospital in Morrisville (Green Mountain Psychiatric Care Center) also secured JCAHO accreditation, and DMH anticipates it will receive deemed status for its certification by the Centers for Medicare and Medicaid Services (CMS) in FFY 14. These additional temporary beds have alleviated some of the demand in an already stretched psychiatric inpatient system of care.

Pending completion of the new state hospital, DMH also continued to contract with Fletcher Allen Health Care (FAHC) for additional psychiatric inpatient beds for patients who would have been served by the former state-run hospital. "Level 1" patients, psychiatrically complex and/or other complicated needs individuals who would otherwise have been hospitalized at the former state-run hospital, were codified through formal payment agreements with FAHC, as well as Brattleboro Treat and RRMC, to assure that individuals needing inpatient mental health care would not be waiting for excessive periods in emergency rooms awaiting a hospital admission. Other existing psychiatric inpatient service capacity provided by Central Vermont Medical Center and the Windham Center remains part of the ongoing continuum of inpatient care service options. This geographic distribution of acute inpatient services provides individuals with inpatient options closer to home which can be very important to their recovery and discharge planning needs.

Care Management

DMH's care management system, to support patient access and flow into acute care hospitalization or diversion when clinically appropriate and step-down transition from inpatient care, continues in earnest to triage and manage the inpatient needs and system movement. Staffed by department care management personnel, 24/7 admissions personnel of the former state hospital, and monitored by a web-based electronic bed board of inpatient and crisis bed census information that is available to service providers, components of the care management system have been operational with availability of staff and administrators weekdays and 24/7 on weekends throughout this period. Community and inpatient treatment providers have access to these centralized resources to assist with systemic issues or barriers that might arise as an individual moves through the continuum of care. The centralized department function supports timely access to the most acute levels of care and movement to lesser levels of care as quickly as clinically appropriate for individuals, consistent with the statutory directives outlined in Act 79.

Community System Development

Vermont was able to leverage Global Commitment funding to more flexibly support the under and uninsured needs for persons who would otherwise have been served at the state hospital. Services that had been paid for only with state general funds were able to be matched in large part with federal Medicaid and Medicare dollars when provided in alternative care settings and the community. Vermont's mental health care system has been working to provide evidence based and innovative practices to help people with recovery, to live independently, to work, and to fully participate in their communities. During this FFY, DMH made significant resource investments into community-based mental health services in the following ways:

Expand and Improve Emergency, Crisis, and Residential Support

There has been broad consensus that emergency services and supports need to be more consistent, flexible and mobile. Services need to be able to respond to people in supportive ways, where they are, and be available 24/7 every day. Services also need to integrate with local law enforcement, hospital emergency rooms and peer services where they exist. Given the anticipated and growing demand for mental health support services in a state experiencing a smaller capacity of acute psychiatric inpatient care, access to psychiatic evaluation has been an essential cornerstone of mental health service reform. As such, Designated Agencies (DA's) have continued to develop and enhance emergency outreach and crisis support services at the local level. Mobile response capability and improved collaborations with local law enforcement are emphasized to better meet the challenges of providing effective engagement in a rural state.

During this FFY, DMH continued to work with law enforcement, advocacy organizations, and mental health service providers to address county-wide needs, enhance service collaboration planning and develop alternative forms of transportation for individuals being hospitalized. The flexible application of Global Commitment resources has supported further development of both trauma sensitive and least restrictive modes of transportation consistent with increased safety needs. Collaboration with law enforcement and training in alternative transport options, when clinically appropriate, have already had a positive influence on reducing the use of hard restraints for acute emergency mental health transports as the norm. For example, during the first quarter of FFY 13, the use of restraints during involuntary transports fell below the 50% threshold; and, if restraints were used, the use of metal restraints fell below 20%.

Multiple regions of the state have also developed crisis bed stabilization capabilities where limited or no capacity existed before. In total, crisis bed programs have grown from 27 beds to 39 beds and are an excellent resource for hospital step-down and hospital diversion at a daily average of 50-75% lower cost than hospitals. DMH has seen a significant increase in usage as these beds expand from a regional to a statewide resource.

Act 79 also supported the investment of Global Commitment resources into intensive residential recovery support programs. These facilities are intended to serve people who no longer need acute inpatient care but are not yet ready for full independent living. These program environments assist individuals in their recovery by providing a safe and secure setting and therapeutic services aimed at returning persons served to their communities. New programs that began operation in FFY 13 include:

Middlesex Therapeutic Community Residence (MTCR): This state-run, secure 7-bed residential facility targets individuals who are ready for step down from acute inpatient care, but still require a secure program as a point of transition into the community. Individuals admitted to the facility are placed on orders of non-hospitalization with conditions that include a requirement to reside at this secure program. Residents considered for this residential facility must be reasonably stable in their recovery process as the facility does not routinely employ involuntary emergency procedures in response to behavioral dysregulation. The physical environment maximizes indoor space with quiet areas and ample outside space within secure perimeters.

Second Spring – Westford: This intensive residential recovery program will provide greater access to this level of care in northwestern Vermont while also sharing resources with Second Spring Williamstown in Orange County. The 8-bed residence will be utilized primarily as a step-down program for individuals leaving one of Vermont's Level I inpatient hospital units.

DMH also supported the ongoing operation of the newly established Hillhouse 8-bed residential program in Westminster, VT, which has offered some relief to the inpatient care system and individuals ready to step-down to a lesser level of care.

Development of two additional residential programs continues to more forward. Pathways-Vermont is on-track to open a five-bed residential program as an alternative treatment option for individuals seeking to avoid or reduce reliance on medication in early 2015, and Rutland Mental Health Services continues to work toward the completion of a 4-bed intensive residential recovery program in Rutland with room for expanding the building to eight beds without changing the building footprint.

Flexible Outpatient Services

Developing a stronger outpatient service in the DA's, with a strong emphasis on identifying and responding to people at risk, was also a key component of the mental health system reform efforts. Services must be flexible and person-centered to respond to the real needs and choices of the individuals. Having available case management to meet the needs of people who do not meet other eligibility criteria was often identified as a "gap" service. Inroads for the outpatient services population were made via the expansion of "service planning and coordination supports" or case management services that extended beyond the severe and persistently mentally ill population. More responsive, hands-on case management support services to stabilize individuals who might otherwise further decompensate from mental health stressors or exhaust existing coping mechanisms were supported through Act 79. What has been called "non-categorical" case management is an expanded service capacity that is no longer reserved for the most incapacitated

individuals served in community-based programs. Earlier supportive intervention available to individuals struggling with mental health issues will further reduce potential need for limited acute inpatient resources. A population targeted for these support services, which are at risk for higher cost public and health care resource utilization, are individuals transitioning between periods of incarceration and re-entry to the community. Individuals at risk for recidivism, law enforcement involvement and incarceration, are a continuing priority group for expanded mental health and community support services. DMH expects that this service capacity will meet the needs of an expanded group of persons served and will continue to grow in the upcoming year.

Housing Subsidies

Act 79 also provided for new investment in housing supports and coordinated treatment supports to provide greater stabilization in the community for individual at higher risk for homelessness. The pairing of both treatment and stable housing resources increases the likelihood of individuals with mental health needs remaining more engaged with services and less likely to destabilize requiring acute inpatient treatment. Stable housing is one of the most important elements in preventing crisis and in supporting recovery. Yet, persons with mental health conditions often find themselves struggling to maintain stable housing and even worse, are at high risk for homelessness. DMH allocated funds during this FFY to establish housing subsidies to ensure stable housing.

Housing assistance is being provided as much as possible in the "housing first" model, in which housing is provided without pre-qualification or agreements to accept certain services in order to receive assistance. However, when desired, DMH though its DA network is employing support services from minimal case management to full wrap-around plans to keep the individual successfully housed. Augmenting formal support services with peer support services is also being promoted to further support stability and linkages in the community.

Peer Services

Act 79 also supported investments in alternative services provided by individuals with the lived experience of mental illness (peers) to broaden the array and options for recovery supports to individuals with mental illness. the lived experience of mental illness (peers). These services include: community outreach, support groups, local peer-run initiatives, education, advocacy, transition support between hospital and community treatment settings, hospital diversion and step-down, crisis respite, and pre-crisis telephone-based support, referral and emotional support. DMH also funds family-to-family peer support for people who have a family member with severe mental illness.

Chart Thirty-One: Peer Supported Programming

Organization	Services Provided
Another Way	Community center providing outreach, community and network building, support groups, service linkages, crisis prevention, and employment supports.
Alyssum	Two-bed program providing crisis respite and hospital diversion and step-down.
NAMI-VT	Statewide family and peer organization providing support groups, educational and advocacy groups.
Northeast Kingdom Youth Services	Community Outreach, support groups and crisis intervention for young adults at risk of hospitalization.
Pathways – Peer Support Line	Statewide telephone peer support to prevent crisis and provide wellness coaching.
Vermont Psychiatric Survivors	Statewide organization providing community outreach, support groups, local peer-run micro-initiatives, telephone support, referral and emotional support, education, advocacy, and transition support between hospital and community treatment settings.
Vermont Vet-to-Vet	Community outreach, support groups and crisis intervention for veterans at risk of hospitalization due to mental health and substance use challenges.

DMH is also piloting the use of individual recovery outcomes tools at contracted peer-run programs through a federal Mental Health Transformation grant. Two programs are currently collecting National Outcome Measures (NOMS) and the Peer-Operated Protocol (POP), and outcome data will be available in the coming months.

DMH has also contracted with the Vermont Center for Independent Living (VCIL) to coordinate and support the development of a Wellness Workforce Coalition (WWC) for organizations and individuals offering peer-based services and supports to individuals with mental health and other co-occurring challenges. This network will support the expansion, coordination, and quality improvement of peer services in the state, including:

- Coordinating core training (Intentional Peer Support, Wellness Recovery Action Planning)
- Workforce development (e.g. recruitment, retention, career development)
- Mentoring
- Quality improvement
- Coordination of peer services

Communication and networking

- Systems advocacy.

VI. Utilization Management

Utilization Management is a systematic evaluation of the necessity, appropriateness, and efficiency of managed care model services. These activities are designed to influence providers' resource utilization and clinical practice decisions in a manner consistent with established criteria or guidelines to maximize appropriate care and minimize or eliminate inappropriate care. The DVHA must have a mechanism to detect both under/over-utilization of services and to assess the quality and appropriateness of care furnished to enrollees with special health care needs.

i. Clinical Utilization Review Board

The Clinical Utilization Review Board (CURB) was established by Act 146 Sec. C34, 33 V.S.A. Chapter 19, Subchapter 6 during the 2010 legislative session. The DVHA was tasked to create the CURB to examine existing medical services, emerging technologies, and relevant evidence-based clinical practice guidelines and make recommendations to the DVHA regarding coverage, unit limitations, place of service, and appropriate medical necessity of services in the state's Medicaid programs.

The CURB is comprised of 10 members with diverse medical experience, appointed by the Governor upon recommendation of the DVHA Commissioner. The CURB solicits additional input as needed from individuals with expertise in areas of relevance to the CURB's deliberations. The Medical Director of DVHA serves as the State's liaison to CURB.

The CURB has the following duties and responsibilities:

1) Identify and recommend to the Commissioner opportunities to improve quality, efficiencies, and adherence to relevant evidence-based clinical practice guidelines in the Department's medical programs by:
   a) Examining high-cost and high-use services identified through the programs' current medical claims data;
   b) Reviewing existing utilization controls to identify areas in which improved utilization review might be indicated, including use of elective, nonemergency, out-of-state outpatient and hospital services;
   c) Reviewing medical literature on current best practices and areas in which services lack sufficient evidence to support their effectiveness;
   d) Conferring with commissioners, directors, and councils within the Agency of Human Services and the Department of Financial Regulation, as appropriate, to identify specific opportunities for exploration and to solicit recommendations;
   e) Identifying appropriate but underutilized services and recommending new services for addition to Medicaid coverage;
   f) Determining whether it would be clinically and fiscally appropriate for the DVHA to contract with facilities that specialize in certain treatments and have been recognized by the medical community as having good clinical outcomes and low morbidity and mortality rates, such as transplant centers and pediatric oncology centers; and
   g) Considering the possible administrative burdens or benefits of potential recommendations on providers, including examining the feasibility of exempting from prior authorization requirements those health care professionals whose prior authorization requests are routinely granted.

2) Recommend to the Commissioner the most appropriate mechanisms to implement the recommended evidence-based clinical practice guidelines. Such mechanisms may include prior authorization, prepayment, post service claim review, and frequency limits.

ii. Drug Utilization Review Board

The DUR Board was authorized by Congress under Section 4401, 1927(g) of the Omnibus Reconciliation Act of 1990. This act mandated that the Vermont AHS develop a drug use review program for covered outpatient drugs, effective January 1, 1993. The Act required the establishment of a DUR Board to:

1) Review and approve drug use criteria and standards for both retrospective and prospective drug use reviews (DURs)
2) Apply these criteria and standards in the application of DUR activities
3) Review and report the results of DURs, and
4) Recommend and evaluate educational intervention programs.

Additionally, the Vermont Legislature enacted the Pharmacy Best Practices and Cost Control Program from the Fiscal Year 2002 Appropriations Act, H 485, which mandated that:

"The commissioner of prevention, assistance, transition, and health access [now the Department of Vermont Health Access] shall establish a pharmacy best practices and cost control program designed to reduce the cost of providing prescription drugs, while maintaining high quality in prescription drug therapies. The program shall include a preferred list of covered prescription drugs that identifies preferred choices within therapeutic classes for particular diseases and conditions, including generic alternatives, utilization review procedures, including a prior authorization review process, and any other cost containment activity adopted by rule by the commissioner, designed to reduce the cost of providing prescription drugs while maintaining high quality in prescription drug therapies."

Implementation of this pharmaceutical initiative required that either the DUR Board or a Pharmacy and Therapeutics Committee be established that would provide guidance on the development of a Preferred Drug List for Medicaid patients. The DVHA elected to utilize the already established DUR Board to obtain current clinical advice on the use of pharmaceuticals. Meetings of the DUR Board occur monthly or bimonthly depending upon the numbers of drugs and issues to be reviewed.

The DUR Board typically includes 10-12 members who are appointed to two-year terms. At least one-third, but not more than half, of the Board's members are licensed and actively practicing physicians, and at least one-third of its members are licensed and actively practicing pharmacists. Other interested and qualified people also may be appointed. Board members are recommended by the DVHA Commissioner and approved by the Governor.

iii. Appropriateness of Services

The DVHA delegates to its IGA partners who provide care to the four identified special health care needs populations, the responsibility to develop mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs. The DMH monitors the quality and appropriateness of care to enrollees in the CRT Program through the biennial Minimum Standards Review; and for children identified with severe emotional disturbance through Program Reviews. The Department of Disability, Aging and Independent Living (DAIL) monitors the quality and appropriateness of care to enrollees in the DS Program and the TBI Program through Quality Service Reviews. (For further descriptions of the delegated activities see the individual departments' quality plans.)

iv. Program Integrity Unit

The AHS has delegated responsibility for program integrity to the DVHA's Program Integrity (PI) Unit. The PI Unit strives to ensure that Medicaid funds are utilized appropriately by identifying and ultimately reducing fraud, waste and abuse.

The PI Unit works with providers, beneficiaries, the Medicaid Fraud and Residential Abuse Unit (MFRAU) of the Office of the Attorney General, our fiscal agents, the DVHA units, AHS Departments, and the Medicaid Integrity Contractors (MIC) to insure the integrity of services provided and that actual, medically necessary healthcare services for beneficiaries are provided, coded, billed and paid in accordance with federal and state Medicaid rules, regulations, provider agreements and relevant statutes. Cases of suspected provider fraud are referred to the Medicaid Fraud and Residential Abuse Unit (MFRAU). Beneficiary eligibility fraud is referred to the DCF. Identified quality or process improvement needs are brought to the MCMC.

The PI Unit employs several methods to identify fraud, waste and abuse. Examples include:

- Referrals from providers, pharmacies, national alerts, general public, etc.
- Pre-Payment reviews
- Post-Payment reviews
- Data mining activities

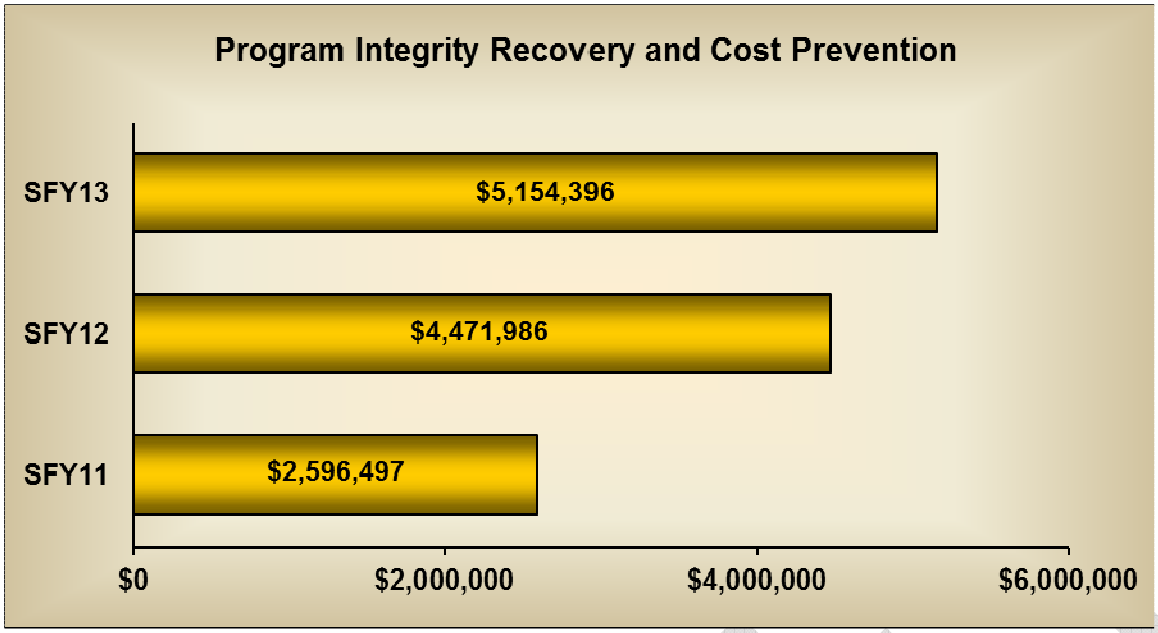
The PI Unit uses claims analysis to detect aberrant billing practices, identify potential findings and perform preliminary investigations. Potential findings are selected for validation through a various investigative approaches. Some examples of more extensive reviews help to determine if the findings are:

- Suspected provider fraud, which may result in a referral to MFRAU;
- Suspected beneficiary eligibility fraud, which is referred to the DCF;
- An unintentional error by the billing entity;
- Errors that indicate a need for education/training and/or clarification of rules, procedures and policy; or
- Determined to be without findings.

a. Outcomes

The Program Integrity Unit in the DVHA has made significant strides in finding, investigating, and preventing fraud, waste and abuse in the Vermont Medicaid program. The annual savings to the State of Vermont was a total of $2.6 million (gross) from recoupment and cost avoidance for SFY 2011 (Figure 1). The total recovery in recoupment and cost avoidance for SFY 2012 was $4.47 million and for SFY 2013 was $5.15 million in.

Figure 1. Program Integrity Recovery and Cost Prevention, by State Fiscal Year



b. Medicaid Management Information System

The Medicaid Management Information System (MMIS) is an integral component of the PI Unit's utilization review activities. The MMIS maintains Medicaid claims data which allows for additional review and scrutiny of claims data.

c. Claims Data Analysis and Post Payment Review

The PI Unit contracted with OptumInsight until 2013 to provide claims data analysis and post payment review. OptumInsight utilized data mining techniques and developed a variety of algorithms to detect aberrant utilization. OptumInsight used Medicaid policies, guidelines and claims data in the development of these algorithms. Reports generated from these reviews identified specific claims data and facilitated PI investigations.

d. Ad Hoc Queries

The PI Unit also utilizes the Enhanced Vermont Ad Hoc (EVAH) system. The EVAH system is a Business Objects application that enables the PI Unit to mine data and create varied and comprehensive ad hoc reports from the MMIS. EVAH is an invaluable tool employed by the PI Unit Medical Health care Data & Statistical Analyst, Fiscal Analyst and Programs and Operations Auditors to advance investigations that enables them to focus on individual elements within each claim.

Data gleaned from EVAH allows the PI Unit to compare claims information submitted by providers. The data can be reported and analyzed using any of the claim details to allow the PI unit to compare individuals, evaluate adherence to policy, etc. This is a valuable tool in detecting under/over-utilization on a global scale.

v. Inpatient, Outpatient, and Emergency Department Utilization

a. Methods

Utilization statistics for inpatient, outpatient, and emergency department services provided under Global Commitment during FFY 2013 were compiled by the DVHA's Data & Reimbursement Unit in December 2013 using paid claims data. The scope of analysis included institutional services provided under the

Medicaid program between 10/1/2012 and 9/30/2013, excluding crossover claims.[1] The following areas of utilization were the focus of this analysis:

- Total Inpatient Utilization
    - Inpatient Medicine
        - Inpatient Medicine – Alcohol and Substance Abuse Services
        - Inpatient Medicine – Psychiatric Services
        - Inpatient Medicine – All Other Services
    - Inpatient Surgery
- Total Outpatient Utilization
    - Emergency Department Utilization

Measures consisted of discharge counts and institutional length-of-stay, in days, for inpatient services, and visit counts for outpatient services. The results were broken out by age category.

b. Findings

The following table (Table 5) presents discharge counts and average length-of-stay by age for inpatient services provided in FFY 2013.

Table 5. Inpatient Utilization

Utilization	Age	Discharges	Sum LOS Days	Avg. LOS Days
TOTAL INPATIENT (IP)	<1	3,265	12,353	3.78
TOTAL INPATIENT (IP)	1-9	536	2,127	3.97
TOTAL INPATIENT (IP)	10-19	1,248	8,183	6.56
TOTAL INPATIENT (IP)	20-44	6,063	24,263	4.00
TOTAL INPATIENT (IP)	45-64	3,243	18,190	5.61
TOTAL INPATIENT (IP)	65-74	66	268	4.06
TOTAL INPATIENT (IP)	75-84	29	140	4.83
TOTAL INPATIENT (IP)	85+	21	86	4.10
TOTAL INPATIENT (IP)	Total	14,471	65,610	4.53
IP MEDICINE	<1	3,237	12,182	3.76
IP MEDICINE	1-9	442	1,784	4.04
IP MEDICINE	10-19	1,037	7,198	6.94
IP MEDICINE	20-44	4,712	18,678	3.96
IP MEDICINE	45-64	2,351	12,488	5.31
IP MEDICINE	65-74	56	203	3.63
IP MEDICINE	75-84	23	101	4.39
IP MEDICINE	85+	19	78	4.11
IP MEDICINE	Total	11,877	52,712	4.44
IP MED ALCOH/SUBST	<1	0	0	0.00
IP MED ALCOH/SUBST	1-9	0	0	0.00
IP MED ALCOH/SUBST	10-19	17	51	3.00
IP MED ALCOH/SUBST	20-44	623	2,725	4.37
IP MED ALCOH/SUBST	45-64	244	1,063	4.36
IP MED ALCOH/SUBST	65-74	0	0	0.00

[1] Crossover claims, or claims for which the State of Vermont was the payer of last resort and paid the remainder of cost for services covered by Medicare.

IP MED ALCOH/SUBST	75-84	0	0	0.00
IP MED ALCOH/SUBST	85+	0	0	0.00
IP MED ALCOH/SUBST	Total	884	3,839	4.34
IP MED PSYCHIATRIC	<1	0	0	0.00
IP MED PSYCHIATRIC	1-9	56	668	11.93
IP MED PSYCHIATRIC	10-19	407	5,115	12.57
IP MED PSYCHIATRIC	20-44	750	6,287	8.38
IP MED PSYCHIATRIC	45-64	302	2,719	9.00
IP MED PSYCHIATRIC	65-74	2	31	15.50
IP MED PSYCHIATRIC	75-84	0	0	0.00
IP MED PSYCHIATRIC	85+	0	0	0.00
IP MED PSYCHIATRIC	Total	1,517	14,820	9.77
IP MED OTHER	<1	3,237	12,182	3.76
IP MED OTHER	1-9	386	1,116	2.89
IP MED OTHER	10-19	613	2,032	3.31
IP MED OTHER	20-44	3,339	9,666	2.89
IP MED OTHER	45-64	1,805	8,706	4.82
IP MED OTHER	65-74	54	172	3.19
IP MED OTHER	75-84	23	101	4.39
IP MED OTHER	85+	19	78	4.11
IP MED OTHER	Total	9,476	34,053	3.59
IP SURGERY	<1	28	171	6.11
IP SURGERY	1-9	94	343	3.65
IP SURGERY	10-19	211	985	4.67
IP SURGERY	20-44	1,351	5,585	4.13
IP SURGERY	45-64	892	5,702	6.39
IP SURGERY	65-74	10	65	6.50
IP SURGERY	75-84	6	39	6.50
IP SURGERY	85+	2	8	4.00
IP SURGERY	Total	2,594	12,898	4.97

The following table (Table 6) presents visit counts by age for outpatient services provided in FFY 2013, first for all outpatient services, and then for emergency department services.

Table 6. Outpatient Utilization

Age	TOTAL OUTPATIENT (OP) Visits	OP EMERG DEPT Visits
<1	6,367	3,042
1-9	33,759	15,079
10-19	42,876	14,685
20-44	142,636	39,894
45-64	94,149	12,777
65-74	977	120
75-84	406	29
85+	250	25
Total	321,420	85,651

c. Discussion

In FFY 2013, Global Commitment, Medicaid, paid for 14,471 inpatient stays and 321,420 outpatient visits for Vermonters. Of the inpatient stays, 82% were for medicine, and 18% were for surgery. Psychiatric services constituted 10% of the inpatient medicine stays, and treatment for alcohol and substance abuse services constituted 6% of inpatient medicine stays. Compared to other inpatient stays, alcohol/substance-abuse stays were moderately longer in average duration (similar to that for inpatient surgery), and psychiatric stays were substantially longer. Among outpatient visits, emergency department visits constituted roughly 27%.

VII. Policy and Administrative Difficulties

Fiscal & Operational Management

AHS and DVHA worked diligently on waiver renewal during FFY13, which was approved for October 2, 2013 through December 31, 2016. Vermont intends to work with CMS include the current Long Term Care (i.e., Choices for Care Waiver) and CHIP populations under the Global Commitment demonstration authority during CY2014.

AHS paid DVHA a prospective PMPM capitation payment on the first business day of every month during FFY12. The PMPM payments included retroactive changes in enrollment with a 12-month runout period, per our PMPM payment process. In accordance with the amended Standard Terms and Conditions, effective with the waiver renewal on January 1, 2011, this PMPM payment served as the proxy by which to draw down Federal funds for Global Commitment. Effective with the filing of the QE0311 CMS-64 report, the State began claiming based upon actual allowable Medicaid expenditures (administrative, program, and MCE Investments), versus the previous practice of claiming Federal Medicaid dollars based upon the PMPM calculation.

AHS contracted with Milliman, Inc. as its actuarial services vendor effective April 1, 2012, for the FFY13 and FFY14 periods. AHS selected PMPM rates and sent an IGA for the FFY13 period to CMS on October 4, 2012. AHS worked with CMS throughout FFY13 toward continued resolution of issues pertaining to approval of the FFY11, FFY12 and FY13 IGAs and selected PMPM rates. Vermont would bear a significant retroactive and ongoing financial risk in the event the selected PMPM rates in the IGAs and actuarial certifications for FFY11, FFY12 and FFY13 are not approved as submitted. Resolution of the remaining issues as expediently as possible remains a top priority for the State.

CMS deferred Vermont's GlobalRx claims for QE1212, QE0313, and QE0613; these deferrals caused cash flow shortfalls until AHS received notice from CMS on December 17, 2013 that the deferrals had been released and no further deferral action would be taken on this issue.

AHS worked with DVHA and HP throughout FFY13 to ensure that the State's reporting system supports all MBES requirements; work continues with HP to support all ACA reporting requirements, including identification of those services reimbursed at a different Federal match rate and in support of the revised MEG bucketing effective with the October 2, 2013 STCs.

Vermont has experienced delays with implementation of certain IAPD projects and has had significant back and forth with CMS regarding approval of grant funding. Additionally, Vermont has submitted SPAs for the New Adult enhancement match and the expansion state 2.2% enhancement rate for 1/1/2014-12/31/201. As of April 2014, these SPAs have not yet been approved, which has presented a cash flow shortfall for the State; AHS expects to receive timely approval so that Vermont can draw in the Federal funds to which we are entitled.

Due to technical difficulties with Vermont's Health Care Exchange website, certain populations previously slated to transition on 12/31/2013 was extended through 3/31/2014, after the Affordable Care Act became effective on January 1, 2014. Impacted eligibility groups include segments of the VHAP, Catamount, ESI, and Pharmacy Only populations.

AHS' Financial Manager responsible for quarterly CMS-64/CMS-21/CMS-37/CMS-21B reporting, Connie Harrison, left AHS Central Office in December 2012 to accept a position at DVHA as Medicaid Fiscal Analyst. The AHS Financial Manager position was filled by Ben Black, who previously served as a Financial Administrator within the AHS Central Office.

In December 2012, Stephanie Beck formally replaced Suzanne Santarcangelo as the AHS Director of Health Care Operations, Compliance and Improvement. Stephanie served as the AHS lead for the Global Commitment Waiver until April 2014, when she was appointed Program Director for AHS' Health Services Enterprise. Monica Light, Financial Director within the AHS Central Office, replaced Stephanie Beck as the AHS Director of Health Care Operations, Compliance and Improvement in April 2014. The AHSCO Financial Director position is under recruitment as of April 2014.

VIII. Capitated Revenue Spending

The PMPM rates as set for waiver year eight are listed below.

Medicaid Eligibility Group	Monthly Premium PMPM
ABD - Non-Medicare - Adult	**$ 1,307.43**
ABD - Non-Medicare - Child	**$ 2,625.41**
ABD - Dual	**$ 1,342.14**
ANFC - Non-Medicare - Adult	**$ 720.03**
ANFC - Non-Medicare - Child	**$ 441.01**
GlobalExp (VHAP)	**$ 472.80**
GlobalRx - Dual	**$ 65.18**
GlobalRx - Non-Medicare	**$ 81.13**
OptionalExp	**$ 217.22**
VHAP ESI	**$ 213.50**
ESI Premium Assistance	**$ 158.90**
Catamount Premium Assistance	**$ 473.30**

Investments made by the MCE for State fiscal year 2013 totaled $123,669,882. Areas of capitated spending and the associated categories are outlined in Attachment 1.

Attachments

Attachment 1

MCO Investment Expenditures

Department	Criteria	Investment Description	SFY06 Actuals - 3/4 SFY	SFY07 Actuals	SFY08 Actuals	SFY09 Actuals	SFY10 Actuals	SFY11 Actuals	SFY12 Actuals	SFY13 Actuals
DOE	2	School Health Services	$ 6,397,319	$ 8,956,247	$ 8,956,247	$ 8,956,247	$ 8,956,247	$ 4,478,124	$ 11,027,579	$ 9,741,252
AOA	4	Blueprint Director	$ -	$ -	$ 70,000	$ 68,879	$ 179,284	$ -	$ -	$ -
GMCB	4	Green Mountain Care Board	$ -	$ -	$ -	$ -	$ -	$ -	$ 789,437	$ 1,450,717
BISHCA	2	Health Care Administration	$ 983,637	$ 914,629	$ 1,340,728	$ 1,871,651	$ 1,713,959	$ 1,898,342	$ 1,897,997	$ 659,544
DII	4	Vermont Information Technology Leaders	$ 266,000	$ 105,000	$ 105,000	$ 339,500	$ -	$ -	$ -	$ -
VVH	2	Vermont Veterans Home	$ 747,000	$ 913,047	$ 913,047	$ 881,043	$ 837,225	$ 1,410,956	$ 1,410,956	$ 1,410,956
VSC	2	Health Professional Training	$ 283,154	$ 391,698	$ 405,407	$ 405,407	$ 405,407	$ 405,407	$ 405,407	$ 405,407
UVM	2	Vermont Physician Training	$ 2,798,070	$ 3,870,682	$ 4,006,152	$ 4,006,156	$ 4,006,152	$ 4,006,156	$ 4,006,156	$ 4,006,156
VAAFM	3	Agriculture Public Health Initiatives	$ -	$ -	$ -	$ -	$ -	$ -	$ 90,278	$ 90,278
AHSCO	2	Designated Agency Underinsured Services	$ -	$ -	$ -	$ -	$ -	$ 2,510,099	$ 5,401,947	$ 6,232,517
AHSCO	4	2-1-1 Grant	$ -	$ -	$ -	$ 415,000	$ 415,000	$ 415,000	$ 415,000	$ 415,000
VDH	2	Emergency Medical Services	$ 174,482	$ 436,642	$ 626,728	$ 427,056	$ 425,870	$ 333,488	$ 274,417	$ 378,168
VDH	2	AIDS Services/HIV Case Management	$ 152,945	$ -	$ -	$ -	$ -	$ -	$ -	$ -
VDH	2	TB Medical Services	$ 27,052	$ 29,129	$ 15,872	$ 28,359	$ 41,313	$ 36,284	$ 39,173	$ 34,046
VDH	3	Epidemiology	$ 326,708	$ 427,075	$ 416,932	$ 204,646	$ 241,932	$ 315,135	$ 329,380	$ 766,053
VDH	3	Health Research and Statistics	$ 276,673	$ 403,244	$ 404,431	$ 217,178	$ 254,828	$ 289,420	$ 439,742	$ 497,700
VDH	2	Health Laboratory	$ 1,369,982	$ 1,908,982	$ 2,012,252	$ 1,522,578	$ 1,875,487	$ 1,912,034	$ 1,293,671	$ 2,885,451
VDH	4	Tobacco Cessation: Community Coalitions	$ 938,056	$ 1,647,129	$ 1,144,713	$ 1,016,685	$ 535,573	$ 94,089	$ 371,646	$ 498,275
VDH	3	Statewide Tobacco Cessation	$ -	$ -	$ -	$ 230,985	$ 484,998	$ 507,543	$ 450,804	$ 487,214
VDH	2	Family Planning	$ 365,320	$ 122,961	$ 169,392	$ 300,876	$ 300,876	$ 275,803	$ 420,823	$ 1,574,550
VDH	4	Physician/Dentist Loan Repayment Program	$ 810,716	$ 439,140	$ 930,000	$ 1,516,361	$ 970,000	$ 900,000	$ 970,000	$ 970,105
VDH	2	Renal Disease	$ 15,000	$ 7,601	$ 16,115	$ 15,095	$ 2,053	$ 13,689	$ 1,752	$ 28,500
VDH	2	Newborn Screening	$ 74,899	$ 166,795	$ 136,577	$ -	$ -	$ -	$ -	$ -
VDH	2	WIC Coverage	$ 161,804	$ 1,165,699	$ 562,446	$ 86,882	$ -	$ 36,959	$ -	$ 77,743
VDH	4	Vermont Blueprint for Health	$ 92,049	$ 1,975,940	$ 753,087	$ 1,395,135	$ 1,417,770	$ 752,375	$ 454,813	$ 875,851
VDH	4	Area Health Education Centers (AHEC)	$ -	$ 35,000	$ 310,000	$ 565,000	$ 725,000	$ 500,000	$ 540,094	$ 496,176
VDH	4	Community Clinics	$ -	$ -	$ -	$ 640,000	$ 468,154	$ 640,000	$ 600,000	$ 640,000
VDH	4	FQHC Lookalike	$ -	$ -	$ 30,000	$ 105,650	$ 81,500	$ 87,900	$ 102,545	$ 382,800
VDH	4	Patient Safety - Adverse Events	$ -	$ -	$ 190,143	$ 100,509	$ 44,573	$ 16,829	$ 25,081	$ 42,169
VDH	4	Coalition of Health Activity Movement Prevention Program (CHAMPPS)	$ -	$ 100,000	$ 291,298	$ 486,466	$ 412,043	$ 290,661	$ 318,806	$ 345,930
VDH	2	Substance Abuse Treatment	$ 1,466,732	$ 2,514,963	$ 2,744,787	$ 2,997,668	$ 3,000,335	$ 1,693,198	$ 2,928,773	$ 2,435,796
VDH	4	Recovery Centers	$ 171,153	$ 287,374	$ 329,215	$ 713,576	$ 716,000	$ 648,350	$ 771,100	$ 864,526
VDH	2	Immunization	$ -	$ -	$ -	$ 726,264	$ -	$ -	$ 23,903	$ 457,757
VDH	2	DMH Investment Cost in CAP	$ -	$ -	$ -	$ 64,843	$ -	$ 752	$ 140	$ -
VDH	4	Poison Control	$ -	$ -	$ -	$ -	$ 176,340	$ 115,710	$ 213,150	$ 152,250
VDH	4	Challenges for Change: VDH	$ -	$ -	$ -	$ -	$ -	$ -	$ 309,645	$ 353,625
VDH	3	Fluoride Treatment	$ -	$ -	$ -	$ -	$ -	$ -	$ 43,483	$ 75,081
VDH	4	CHIP Vaccines	$ -	$ -	$ -	$ -	$ -	$ -	$ 196,868	$ 482,454
VDH	4	Healthy Homes and Lead Poisoning Prevention Program	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 101,127
DMH	2	Special Payments for Treatment Plan Services	$ 101,230	$ 131,309	$ 113,314	$ 164,356	$ 149,068	$ 134,791	$ 132,021	$ 180,773
DMH	2	MH Outpatient Services for Adults	$ 775,899	$ 1,393,395	$ 1,293,044	$ 1,320,521	$ 864,815	$ 522,595	$ 974,854	$ 1,454,379
DMH	2	Mental Health Elder Care	$ 38,563	$ 37,682	$ 38,970	$ -	$ -	$ -	$ -	$ -
DMH	4	Mental Health Consumer Support Programs	$ 451,606	$ 546,987	$ 673,160	$ 707,976	$ 802,579	$ 582,397	$ 67,285	$ 1,649,340
DMH	2	Mental Health CRT Community Support Services	$ 2,318,668	$ 602,186	$ 807,539	$ 1,124,728	$ -	$ 1,935,344	$ 1,886,140	$ 6,047,450
DMH	2	Mental Health Children's Community Services	$ 1,561,396	$ 3,066,774	$ 3,341,602	$ 3,597,662	$ 2,569,759	$ 1,775,120	$ 2,785,090	$ 3,088,773
DMH	2	Emergency Mental Health for Children and Adults	$ 1,885,014	$ 1,988,548	$ 2,016,348	$ 2,165,648	$ 1,797,605	$ 2,309,810	$ 4,395,885	$ 8,719,824
DMH	2	Respite Services for Youth with SED and their Families	$ 385,581	$ 485,586	$ 502,237	$ 412,920	$ 516,677	$ 543,635	$ 541,707	$ 823,819
DMH	2	CRT Staff Secure Transportation	$ -	$ -	$ 52,242	$ -	$ -	$ -	$ -	$ -
DMH	2	Recovery Housing	$ -	$ -	$ 235,267	$ -	$ 332,635	$ 512,307	$ 562,921	$ 874,194
DMH	2	Transportation - Children in Involuntary Care	$ 4,768	$ 1,075	$ -	$ -	$ -	$ -	$ -	$ -
DMH	2	Vermont State Hospital Records	$ -	$ -	$ -	$ -	$ 19,590	$ -	$ -	$ -
DMH	4	Challenges for Change: DMH	$ -	$ -	$ -	$ -	$ -	$ 229,512	$ 945,051	$ 819,069
DMH	2	Seriously Functionally Impaired: DMH	$ -	$ -	$ -	$ -	$ -	$ 68,713	$ 160,560	$ 1,151,615
DMH	2	Acute Psychiatric Inpatient Services	$ -	$ -	$ -	$ -	$ -	$ -	$ 12,603,067	$ 5,268,556
DMH	2	Institution for Mental Disease Services: DMH	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 10,443,654
DVHA	4	Vermont Information Technology Leaders/HIT/HIE/HCR	$ -	$ -	$ -	$ -	$ 339,500	$ 646,220	$ 1,425,017	$ 1,517,044
DVHA	4	Vermont Blueprint for Health	$ -	$ -	$ -	$ -	$ -	$ 2,616,211	$ 1,841,690	$ 2,002,798
DVHA	1	Buy-In	$ 4,594	$ 314,376	$ 419,951	$ 248,537	$ 200,868	$ 50,605	$ 24,000	$ 17,878
DVHA	1	Vscript Expanded	$ 1,695,246	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DVHA	1	HIV Drug Coverage	$ 31,172	$ 42,347	$ 44,524	$ 48,711	$ 38,904	$ 39,176	$ 37,452	$ 39,881
DVHA	1	Civil Union	$ 373,175	$ 543,986	$ 671,941	$ 556,811	$ 627,976	$ 999,084	$ 1,215,109	$ 1,112,119
DVHA	1	Vpharm	$ -	$ -	$ -	$ 278,934	$ 210,796	$ -	$ -	$ -
DVHA	4	Hospital Safety Net Services	$ -	$ -	$ 281,973	$ -	$ -	$ -	$ -	$ -
DVHA	2	Patient Safety Net Services	$ -	$ -	$ -	$ -	$ -	$ 36,112	$ 73,487	$ 2,394
DVHA	2	Institution for Mental Disease Services: DVHA	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 6,214,805
DVHA	2	Family Supports	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 4,015,491
DCF	2	Family Infant Toddler Program	$ -	$ 199,064	$ 326,424	$ 335,235	$ 81,086	$ 624	$ -	$ -
DCF	2	Medical Services	$ 69,893	$ 91,569	$ 120,494	$ 65,278	$ 45,216	$ 64,496	$ 47,720	$ 37,164
DCF	2	Residential Care for Youth/Substitute Care	$ 9,181,386	$ 10,536,996	$ 10,110,441	$ 9,392,213	$ 8,033,068	$ 7,853,100	$ 9,629,269	$ 10,131,790
DCF	2	AABD Admin	$ 988,557	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DCF	2	AABD	$ 2,415,100	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DCF	2	Aid to the Aged, Blind and Disabled CCL Level III	$ 96,000	$ 2,617,350	$ 2,615,023	$ 2,591,613	$ 2,827,617	$ 2,661,246	$ 2,563,226	$ 2,621,786
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level III	$ -	$ 143,975	$ 170,117	$ 172,173	$ 137,356	$ 136,466	$ 137,833	$ 124,731
DCF	2	Aid to the Aged, Blind and Disabled Res Care Level IV	$ 210,989	$ 312,815	$ 349,887	$ 366,161	$ 299,488	$ 265,812	$ 273,662	$ 269,121
DCF	2	Essential Person Program	$ 542,382	$ 675,860	$ 614,974	$ 620,052	$ 485,536	$ 736,479	$ 775,278	$ 783,860
DCF	2	GA Medical Expenses	$ 254,154	$ 339,928	$ 298,207	$ 380,000	$ 583,080	$ 492,079	$ 352,451	$ 275,187
DCF	2	CUPS/Early Childhood Mental Health	$ -	$ -	$ 52,825	$ 499,143	$ 166,429	$ 112,619	$ 165,016	$ 45,491
DCF	2	VCRHYP/Vermont Coalition for Runaway and Homeless Youth Program	$ -	$ -	$ 1,764,400	$ -	$ -	$ -	$ -	$ -
DCF	2	HBKF/Healthy Babies, Kids & Families	$ -	$ -	$ 318,321	$ 63,921	$ -	$ -	$ -	$ -
DCF	1	Catamount Administrative Services	$ -	$ -	$ -	$ 339,894	$ -	$ -	$ -	$ -
DCF	2	Therapeutic Child Care	$ -	$ -	$ -	$ 978,886	$ 577,259	$ 570,493	$ 596,406	$ 557,599
DCF	2	Lund Home	$ -	$ -	$ -	$ 325,516	$ 175,378	$ 196,159	$ 354,528	$ 181,243
DCF	2	GA Community Action	$ -	$ -	$ -	$ -	$ -	$ 199,762	$ 338,275	$ 420,359
DCF	3	Prevent Child Abuse Vermont: Shaken Baby	$ -	$ -	$ -	$ -	$ -	$ 44,119	$ 74,250	$ 86,969
DCF	3	Prevent Child Abuse Vermont: Nurturing Parent	$ -	$ -	$ -	$ -	$ -	$ -	$ 107,184	$ 186,916
DCF	4	Challenges for Change: DCF	$ -	$ -	$ -	$ -	$ -	$ 50,622	$ 196,378	$ 197,426
DCF	2	Strengthening Families	$ -	$ -	$ -	$ -	$ -	$ -	$ 465,343	$ 429,154
DCF	2	Lamoille Valley Community Justice Project	$ -	$ -	$ -	$ -	$ -	$ -	$ 162,000	$ 216,000
DCF	3	Building Bright Futures	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 398,201
DDAIL	2	Elder Coping with MMA	$ 441,234	$ -	$ -	$ -	$ -	$ -	$ -	$ -
DDAIL	2	Mobility Training/Other Svcs.-Elderly Visually Impaired	$ 187,500	$ 250,000	$ 250,000	$ 250,000	$ 245,000	$ 245,000	$ 245,000	$ 245,000
DDAIL	2	DS Special Payments for Medical Services	$ 394,055	$ 192,111	$ 880,797	$ 522,058	$ 469,770	$ 757,070	$ 1,498,083	$ 1,299,613
DDAIL	2	Flexible Family/Respite Funding	$ 1,086,291	$ 1,135,213	$ 1,341,698	$ 1,364,896	$ 1,114,898	$ 1,103,748	$ 1,103,749	$ 1,088,889
DDAIL	4	Quality Review of Home Health Agencies	$ -	$ 77,467	$ 186,664	$ 126,306	$ 90,227	$ 103,598	$ 128,399	$ 84,139
DDAIL	4	Support and Services at Home (SASH)	$ -	$ -	$ -	$ -	$ -	$ -	$ 773,192	$ 773,192
DDAIL	4	HomeSharing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 310,000
DDAIL	4	Self-Neglect Initiative	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 150,000
DDAIL	2	Seriously Functionally Impaired: DAIL	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,270,247
DOC	2	Intensive Substance Abuse Program (ISAP)	$ 382,230	$ 299,602	$ 310,610	$ 200,000	$ 591,004	$ 591,000	$ 458,485	$ 400,910
DOC	2	Intensive Sexual Abuse Program	$ 72,439	$ 46,078	$ 85,542	$ 88,523	$ 68,350	$ 70,002	$ 60,585	$ 69,311
DOC	2	Intensive Domestic Violence Program	$ 109,692	$ 134,663	$ 230,353	$ 229,166	$ 173,938	$ 174,000	$ 164,218	$ 86,814
DOC	2	Women's Health Program (Tapestry)	$ 460,130	$ 487,344	$ 487,231	$ 527,956	$ -	$ -	$ -	$ -
DOC	2	Community Rehabilitative Care	$ 1,038,114	$ 1,982,456	$ 2,031,408	$ 1,997,499	$ 2,190,924	$ 2,221,448	$ 2,242,871	$ 2,500,085
DOC	2	Return House	$ -	$ -	$ -	$ 51,000	$ -	$ -	$ -	$ 399,999
DOC	2	Northern Lights	$ -	$ -	$ -	$ -	$ 40,000	$ 40,000	$ -	$ 393,750
DOC	4	Challenges for Change: DOC	$ -	$ -	$ -	$ -	$ -	$ -	$ 687,166	$ 524,594
DOC	4	Northeast Kingdom Community Action	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 548,825
DOC	2	Pathways to Housing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 802,488
			$ 45,455,809	$ 55,495,719	$ 59,918,097	$ 62,419,988	$ 55,554,314	$ 56,275,877	$ 89,836,470	$ 123,669,882

Last Updated: September 4, 2013